




Certificate of Need Application Hospital Projects

Exclude hospital projects for sale, purchase, or lease of a hospital, or skilled nursing beds. Use service-specific addendum, if applicable.

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code [\(WAC\) 246-310-990](#).

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington [\(RCW\) 70.38](#) and [WAC 246-310](#), rules and regulations adopted by the Washington State Department of Health. I attest that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer Tom Jensen, Chief Executive Officer  Email Address tjensen@ghcares.com	Date February 28, 2023 Telephone Number 360-537-5115
Legal Name of Applicant Grays Harbor Public Hospital District No 2, dba Harbor Regional Health Address of Applicant 915 Anderson Dr Aberdeen, WA 98520	<input type="checkbox"/> New hospital <input type="checkbox"/> Expansion of existing hospital (identify facility name and license number) Provide a brief project description, including the number of beds and the location. Establishment of an Elective PCI Program in PCI Planning Area 6 Estimated capital expenditure: \$ <u>0</u>

Identify the Hospital Planning Area <u>PCI Planning Area 6</u>										
Identify if this project proposes the addition or expansion of one of the following services: <table><tr><td><input type="checkbox"/> NICU Level II</td><td><input type="checkbox"/> NICU Level III</td><td><input type="checkbox"/> NICU Level IV</td><td><input type="checkbox"/> Specialized Pediatric (PICU)</td><td><input type="checkbox"/> Psychiatric (within acute care hospital)</td></tr><tr><td><input type="checkbox"/> Organ Transplant (identify)</td><td><input type="checkbox"/> Open Heart Surgery</td><td><input checked="" type="checkbox"/> Elective PCI</td><td><input type="checkbox"/> PPS-Exempt Rehab (indicate level)</td><td><input type="checkbox"/> Specialty Burn Services</td></tr></table>	<input type="checkbox"/> NICU Level II	<input type="checkbox"/> NICU Level III	<input type="checkbox"/> NICU Level IV	<input type="checkbox"/> Specialized Pediatric (PICU)	<input type="checkbox"/> Psychiatric (within acute care hospital)	<input type="checkbox"/> Organ Transplant (identify)	<input type="checkbox"/> Open Heart Surgery	<input checked="" type="checkbox"/> Elective PCI	<input type="checkbox"/> PPS-Exempt Rehab (indicate level)	<input type="checkbox"/> Specialty Burn Services
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Certificate of Need Application
to
Establish an Elective PCI Program
in PCI Planning Area 6

February 2023

Section 1

Applicant Description

1. **Provide the legal name and address of the applicant(s) as defined in [WAC 246-310-010\(6\)](#).**

The legal name of the applicant is Grays Harbor Public Hospital District No 2, dba Harbor Regional Health (Harbor). The address of Harbor is:

915 Anderson Dr
Aberdeen, WA 98520

2. **Identify the legal structure of the applicant (LLC, PLLC, etc.) and provide the unified business identifier (UBI).**

As a public hospital district, Harbor is governed by a publicly elected Board of Commissioners and organized under RCW 70.44. This statute authorizes the establishment of public hospital districts to own and operate hospitals and other health care facilities and to provide hospital services and other health care services for the residents of such districts and other persons.

Harbor's UBI number 603-457-387.

3. **Provide the name, title, address, telephone number, and email address of the contact person for this application.**

The requested information is below:

Tom Jensen
Superintendent and Chief Executive Officer
Harbor Regional Health
915 Anderson Dr
Aberdeen, WA 98520
360-537-5117
tjensen@ghcares.org

4. **Provide the name, title, address, telephone number, and email address of the consultant authorized to speak on your behalf related to the screening of this application (if any).**

Jody Carona
Health Facilities Planning & Development
120 1st Avenue West, Suite 100
Seattle, WA 98119
(206) 441-0971
Email: healthfac@healthfacilitiesplanning.com

5. **Provide an organizational chart that clearly identifies the business structure of the applicant(s).**

An organizational chart for Harbor is included in Exhibit 1.

Section 2 Facility Description

1. Provide the name and address of the existing facility.

Harbor Regional Health, the existing facility, is located at:

915 Anderson Dr
Aberdeen, WA 98520

2. Provide the name and address of the proposed facility. If an address is not yet assigned, provide the county parcel number and the approximate timeline for assignment of the address.

This question is not applicable. The cardiac catheterization laboratory (cath lab) is already operational at the current hospital location. This CN simply seeks to add elective PCI capability.

3. Confirm that the facility will be licensed and certified by Medicare and Medicaid. If this application proposes the expansion of an existing facility, provide the existing identification numbers.

Harbor is licensed by the State of Washington and certified by Medicare and Medicaid. The requested numbers are below:

License #: HAC.FS.000000063
Medicare #: 500031
Medicaid #: 1003668/3307907

4. Identify the accreditation status of the facility before and after the project.

Harbor is accredited by DNV. The current accreditation is valid through May 15, 2025.

5. Is the facility operated under a management agreement?

Yes ☐

No ☒

6. Provide the following scope of service information:

Service	Currently Offered?	Offered Following Project Completion?
Alcohol and Chemical Dependency	X	X
Anesthesia and Recovery	X	X
Cardiac Care	X	X
Cardiac Care – Adult Open-Heart Surgery		
Cardiac Care – Pediatric Open Heart Surgery		
Cardiac Care – Adult Elective PCI		X
Cardiac Care – Pediatric Elective PCI		
Diagnostic Services	X	X
Dialysis – Inpatient		
Emergency Services	X	X
Food and Nutrition	X	X
Imaging/Radiology	X	X
Infant Care/Nursery	X	X
Intensive/Critical Care	X	X
Laboratory	X	X
Medical Unit(s)	X	X
Neonatal – Level II		
Neonatal – Level III		
Neonatal – Level IV		
Obstetrics	X	X
Oncology	X	X
Organ Transplant - Adult (list types, if applicable)		
Organ Transplant - Pediatric (list types, if applicable)		
Outpatient Services	X	X
Pediatrics-	X	X
Pharmaceutical	X	X
Psychiatric		
Skilled Nursing/Long Term Care		
Rehabilitation (indicate level, if applicable)		
Respiratory Care	X	X
Social Services	X	X
Surgical Services	X	X

Section 3 Project Description

- 1. Provide a detailed description of the proposed project. If it is a phased project, describe each phase separately. For existing facilities, this should include a discussion of existing services and how these would or would not change as a result of the project.**

Harbor, located in PCI Planning Area 6, has provided an emergency only PCI program since 2019. There is, and has been numeric need, for an additional provider annually as well, since at least 2019 but, and despite demonstrating health disparities and unmet needs, Harbor's prior CN applications for elective PCI have been denied solely because one of the two existing providers in the Planning Area was operating below the volume thresholds set forth in rule. Pertinent portions of WAC 246-310- 755 states:

If the department issues a certificate of need (CON), it will be conditioned to require ongoing compliance with the CON standards. Failure to meet the standards may be grounds for revocation or suspension of a hospital's CON, or other appropriate licensing or certification actions.

(1) Hospitals granted a certificate of need must meet:

(a) The program procedure volume standards within three years from the date of initiating the program; and

After more than 12 years of non-compliance, in February of 2022, the Program entered into a settlement agreement with this provider. This settlement agreement includes the following language:

Additional PCI Program in the Planning Area: *The Department may grant a CN to a new elective PCI program in Planning Area #6 during the pendency of this other appropriate certification action to address noncompliance with minimum volume standards, so long as the CN application for that new program is filed within the term of this agreement identified in paragraph 5, or within three years follow execution of this Agreement, whichever is later.*

Based on this settlement, Harbor understands that the Program will accept and can approve a project under the current rules in the upcoming cycle; assuming that Harbor meets all other general CN requirements as well as specific PCI requirements.

- 2. If your project involves the addition or expansion of a tertiary service, confirm you included the applicable addendum for that service. Tertiary services are outlined under [WAC 246-310-020\(1\)\(d\)\(i\)](#).**

The applicable addendum is included as Section 8 of this application.

3. **Provide a breakdown of the beds, by type, before and after the project. If the project will be phased, include columns detailing each phase.**

Harbor's current set-up bed complement will not change as a result of this project.

	Current	Proposed
General Acute Care	49	49
PPS Exempt Psych	0	0
PPS Exempt Rehab	0	0
NICU Level II	0	0
NICU Level III	0	0
NICU Level IV	0	0
Specialized Pediatric	0	0
Skilled Nursing	0	0
Swing Beds (included in General Acute Care)	0	0
Total	49	49

4. **Indicate if any of the beds listed above are not currently set-up, as well as the reason the beds are not set up.**

Harbor is licensed for 140 beds, but only operates the configuration noted in the table above. The current set up bed complement is adequate to support demand.

5. **With the understanding that the review of a Certificate of Need application typically takes six to nine months, provide an estimated timeline for project implementation, below. For phased projects, adjust the table to include each phase.**

Event	Anticipated Month/Year
Anticipated CN Approval	November 2023
Design Complete	NA
Construction Commenced	NA
Construction Completed	NA
Facility Prepared for Survey	NA
Facility Licensed - Project Complete WAC 246-310-010 (47)	January 1, 2024

6. Provide a general description of the types of patients to be served as a result of this project.

A percutaneous coronary intervention or (PCI) is an invasive but nonsurgical mechanical procedure performed on patients in need of revascularization of obstructed coronary arteries. Conditions that may be treated with PCI include:

Coronary artery disease, a condition in which plaque buildup along the walls of the coronary arteries causes them to narrow and stiffen. Collectively known as angina, this typically results in symptoms such as tightness in the chest, neck, back, and shoulder during physical activity or emotional stress. Patients with angina may also feel breathless or as if they have heartburn or indigestion. If the artery becomes completely blocked, it is known as a total occlusion.

Acute coronary syndrome, a group of conditions in which blood flow to the heart is suddenly reduced or stopped. Heart attacks and unstable angina (new angina symptoms that occur while at rest and without emotional stress) are types of acute coronary syndrome.

Per WAC 246-310-705, "Elective" means a PCI performed on a patient with cardiac function that has been stable in the days or weeks prior to the operation. Elective cases are usually scheduled at least one day prior to the surgical procedure.

7. Provide a copy of the letter of intent that was already submitted according to [WAC 246-310-080](#).

A copy of the letter of intent is included as Exhibit 2.

8. Provide single-line drawings (approximately to scale) of the facility, both before and after project completion. For additions or changes to existing hospitals, only provide drawings of those floor(s) affected by this project.

The requested drawings are included in Exhibit 3.

9. Provide the gross square footage of the hospital, with and without the project.

The gross square footage of the hospital is 163,899. This project does not add any new square footage.

10. **If this project involves construction of 12,000 square feet or more, or construction associated with parking for 40 or more vehicles, submit a copy of either an Environmental Impact Statement or a Declaration of Non-Significance from the appropriate governmental authority. [[WAC 246-03-030\(4\)](#)]**

This project involves no construction.

11. **If your project includes construction, indicate if you've consulted with Construction Review Services (CRS) and provide your CRS project number.**

This project involves no construction.

Section 4
Need ([WAC 246-310-210](#))

1. **List all other acute care hospitals currently licensed under [RCW 70.41](#) and operating in the hospital planning area affected by this project. If a new hospital is approved, but is not yet licensed, identify the facility.**

This application seeks approval for a new elective PCI program in PCI Planning Area 6. There are currently two hospitals performing elective PCI in the Planning, including Providence St. Peter Hospital and MultiCare Capital Medical Center. Both are located in Thurston County.

2. **For projects proposing to add acute care beds, provide a numeric need methodology that demonstrates need in this planning area. The numeric need methodology steps can be found in the Washington State Health Plan (sunset in 1989).**

This application does not propose any increase in acute care beds.

3. **For existing facilities proposing to expand, identify the type of beds that will expand with this project.**

This application does not propose any increase in acute care beds.

4. **For existing facilities, provide the facility's historical utilization for the last three full calendar years. The first table should only include the type(s) of beds that will increase with the project, the second table should include the entire hospital.**

The first table is not applicable as there is no increase or change in any bed units as a result of this project. The requested information for the entire hospital is below:

Entire Hospital	2020	2021	2022
Licensed beds	140	140	140
Available beds	49	49	49
Discharges	2,819	2,464	2,693
Patient days	12,427	11,570	13,259

5. **Provide projected utilization of the proposed facility for the first seven full years of operation if this project proposes an expansion to an existing hospital. Provide projected utilization for the first ten full years if this project proposes new facility. For existing facilities, also provide the information for intervening years between historical and projected. The first table should only include the type(s) of beds that will increase with the project, the second table should include the entire hospital. Include all assumptions used to make these projections.**

This question is not applicable, as this project proposes no expansion of an existing hospital, and no increase in any bed type.

6. **For existing facilities, provide patient origin zip code data for the most recent full calendar year of operation.**

The requested patient origin data for the entire inpatient hospital operation is included as Exhibit 4.

7. **Identify any factors in the planning area that currently restrict patient access to the proposed services.**

Grays Harbor County covers more than 1,900 square miles. The County is as large as the State of Delaware and includes about 77,000 residents. It is predominantly rural. The hospital itself is located in the city of Aberdeen, the largest city in the County. The population of Aberdeen is approximately 17,000. The County includes lands of the [Quinault Indian Nation. \(QIN\)](#). The QIN includes the Quinault and Queets tribes and descendants of five other coastal tribes: Quileute, Hoh, Chehalis, Chinook, and Cowlitz

Driving time from the city of Aberdeen to the next largest city, Olympia, is roughly one hour; but the Program should understand that many of the communities in Western Grays Harbor County are an hour drive from Aberdeen; for example, it takes about an hour to drive from Lake Quinault in the north end of the District to Aberdeen. Driving time to either Seattle or Portland, Oregon from Aberdeen is about two and a half hours.

The District is fully contained in the County and the District includes about 77% of the total population of the County. Both the District and the larger County face a number of health and socioeconomic challenges. Specifically, health care access is compromised by a low provider to population ratio: the ratio of primary care providers per 1,000 population is only 40% of the State average, and preventable hospital stays per 100,000 Medicare enrollees is 23% higher.

The social and economic factors—the social determinants that can contribute to poorer health—are more of a burden within the boundaries of the District and Grays Harbor County than in most other areas of Washington State.

Robert Wood Johnson's 2022 County Health Rankings (CHR) show that Grays Harbor County ranks 37th lowest out of Washington's 39 Counties on health factors, including those that increase the incidence of heart disease in a community. The data shows that smoking rates are 63% higher than the State average, and obesity is 10% higher.

Social determinants of health—the conditions under which people are born, grow, live, work and play—greatly influence the health of a community and its residents. Graduation rates, housing affordability, income/poverty and race are all social determinants. The median household income in the District is 62% of that of the State. Rates of poverty in the County are significantly above the state's rate (60%). In 2021, the latest data produced by OFM's Health Care Research Center, the rate of uninsured in the County was nearly 26% higher than the State overall.

The United Ways of the Pacific Northwest's ALICE report provides county-level estimates of ALICE households and households in poverty. ALICE is an acronym for Asset Limited, Income Constrained, Employed – households that earn more than the Federal Poverty Level (FPL), but less than the basic cost of living for the county (the ALICE Threshold). Combined, the number of ALICE and poverty-level households equals the total population struggling to afford basic needs. According to a recent United Way ALICE Report data, 46% of Grays Harbor County households were living below the ALICE threshold compared to 33% statewide; including 50% of senior households (65 & older).

Most relevant to this CN is that our County's total cardiovascular disease death rate per 100,000 35+, all races for the period of 2019-2021 is 25% higher than the State (499.5 vs. 399). The cardiovascular death rate for the American Indian population in the County is 585.5, dramatically worse than the State at large^[1]. Under current rules, we are forced to refer out-of-area for elective cases but too frequently our patients forego the travel and return to us in need of an emergency procedure. These patients repeatedly tell us that the burden of travelling out of area, and/or the costs of the travel are prohibitive.

A number of studies have demonstrated that transportation barriers are an important barrier to healthcare access, particularly for those with lower incomes or the under/uninsured. Transportation barriers lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use. These consequences are proven to lead to poorer management of chronic illness and thus poorer health outcomes.

The entirety of Grays Harbor County has been designated as a HPSA for primary, dental, and mental health care. These designations are important as more than 30 federal programs depend on the shortage designation to determine eligibility or funding preference to increase the number of physicians and other health professionals who practice in those designated areas.

8. Identify how this project will be available and accessible to underserved groups.

WAC 246-310-210 (2) requires the Program to determine that:

All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services. The assessment of the conformance of a project with this criterion shall include, but not be limited to, consideration as to whether the proposed services makes a contribution toward meeting the health-related needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services, particularly those needs identified in the applicable regional health plan, annual implementation plan, and state health plan as deserving of priority. Such consideration shall include an assessment of the following:

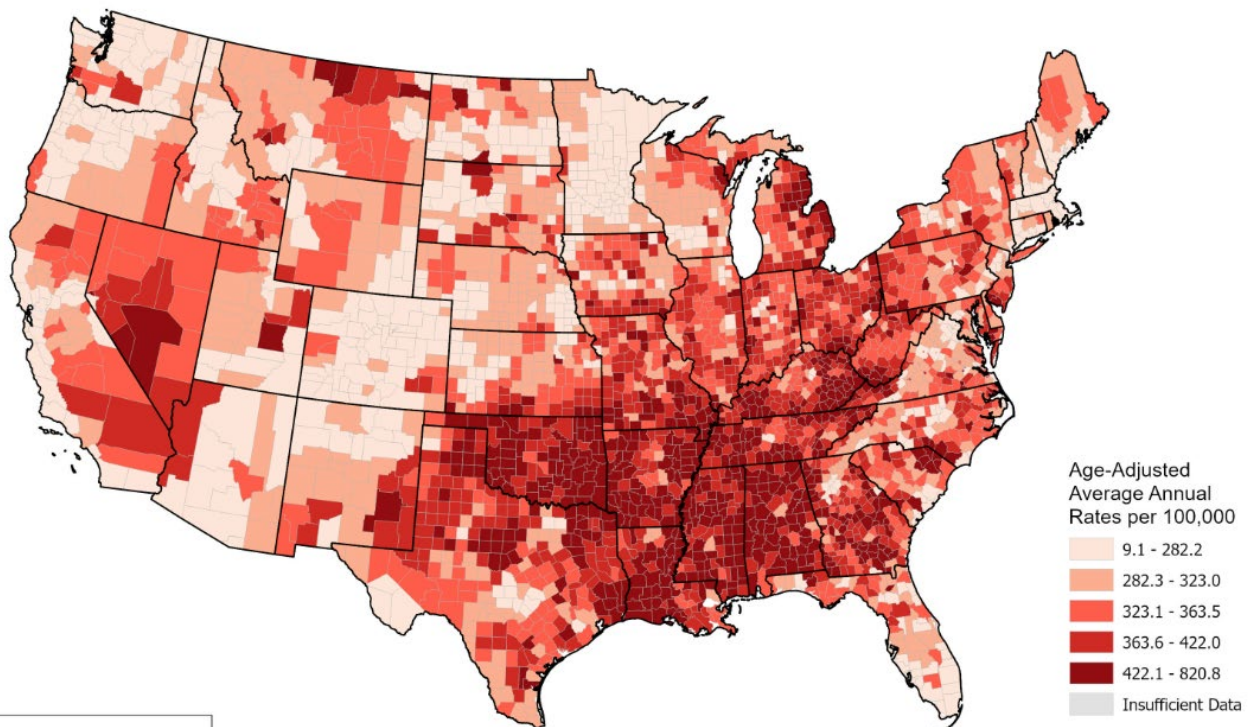
- (a) The extent to which medically underserved populations currently use the applicant's services in comparison to the percentage of the population in the applicant's service area which is medically underserved, and the extent to which medically underserved populations are expected to use the proposed services if approved;*
- (b) The past performance of the applicant in meeting obligations, if any, under any applicable federal regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal financial assistance (including the existence of any unresolved civil rights access complaints against the applicant);*
- (c) The extent to which Medicare, Medicaid, and medically indigent patients are served by the applicant; and*
- (d) The extent to which the applicant offers a range of means by which a person will have access to its services (e.g., outpatient services, admission by house staff, admission by personal physician).*

The Harbor project is laser targeted to make a contribution toward the health-related needs of underserved groups. As noted in response to the question above, Grays Harbor County has the second highest death rate in the State, second only to Pacific County.

Consistent with the state, the leading causes of death in Grays Harbor County are cancer and heart disease. Most relevant to this CN is that our County's total cardiovascular disease death rates are significantly higher than the State; and the American Indian cardiovascular death rate is dramatically worse than the State at large¹. For heart disease, the latest data on the *Healthier WA Collaborative Portal* shows the rate per 100,000 residents age 35+ to be 22% higher in Grays Harbor County than Statewide (320 vs. 262 statewide). The map below reflects this disparity:

¹ Centers for Disease Control and Prevention, National Center for Chronic Disease, Interactive Atlas of Heart Disease and Stroke

**Heart Disease Death Rates, 2018 - 2020
Adults, Ages 35+, by County**



9. **If this project proposes either a partial or full relocation of an existing facility, provide a detailed discussion of the limitations of the current location.**

This project does not propose a partial or full relocation of the facility.

10. **If this project proposes either a partial or full relocation of an existing facility, provide a detailed discussion of the benefits associated with relocation.**

This question is not applicable.

11. Provide a copy of the following policies:

- **Admissions policy**
- **Charity care or financial assistance policy**
- **Patient rights and responsibilities policy**
- **Non-discrimination policy**
- **End of life policy**
- **Reproductive health policy**
- **Any other policies directly associated with patient access**

All requested policies are included in Exhibit 5.

Section 5

Financial Feasibility (WAC 246-310-220)

- 1. Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:**
 - i. Utilization projections. These should be consistent with the projections provided under the Need section. Include all assumptions.**
 - ii. A current balance sheet at the facility level.**
 - iii. Pro forma balance sheets at the facility level throughout the projection period.**
 - iv. Pro forma revenue and expense projections for at least the first three full calendar years following completion of the project. Include all assumptions.**
 - v. For existing facilities, provide historical revenue and expense statements, including the current year. Ensure these are in the same format as the pro forma projections. For incomplete years, identify whether the data is annualized.**

All requested data/proformas is included in Exhibit 6.

2. Identify the hospital's fiscal year.

Harbor is a calendar year hospital.

3. Provide the following agreements/contracts:

- i. Management agreement**
- ii. Operating agreement**
- iii. Development agreement**
- iv. Joint Venture agreement**

There are no such agreements related to the operation of the Hospital.

4. Provide documentation of site control. This could include either a deed to the site or a lease agreement for the site. If a lease agreement is provided, the terms must be for at least five years with options to renew for a total of 20 years.

The property is owned by the District. Harbor has operated at the current address since 1959. A copy of the ownership information from the Assessor's Office is included as Exhibit 7.

- 5. Provide county assessor information and zoning information for the site. If zoning information for the site is unclear, provide documentation or letter from the municipal authorities showing the proposed project is allowable at the identified site. If the site must undergo rezoning or other review prior to being appropriate for the proposed project, identify the current status of the process.**

This question is not applicable. There is no construction or remodeling proposed in this project.

- 6. Complete the table on the following page with the estimated capital expenditure associated with this project. If you include other line items not listed below, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate.**

There is no capital expenditure. Harbor has been operating a cath lab since 2019.

- 7. Identify the entity responsible for the estimated capital costs. If more than one entity is responsible, provide breakdown of percentages and amounts for all.**

There is no capital expenditure. This question is not applicable.

- 8. Identify the start-up costs for this project. Include the assumptions used to develop these costs. Start-up costs should include any non-capital expenditure expenses incurred prior to the facility opening or initiating the proposed service.**

There is no start-up period and no start-up costs. Harbor has been operating a catheterization laboratory since 2019.

- 9. Identify the entity responsible for the start-up costs. If more than one entity is responsible, provide a breakdown of percentages and amounts for all.**

This is not a new service. There are no start-up costs. This question is not applicable.

- 10. Provide a non-binding contractor's estimate for the construction costs for the project.**

There is no construction. This question is not applicable.

11. Provide a detailed narrative supporting that the costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services in the planning area.

There are no capital costs. This question is not applicable.

12. Provide the projected payer mix for the hospital by revenue and by patients using the example table below. Medicare and Medicaid managed care plans should be included within the Medicare and Medicaid lines, respectively. If “other” is a category, define what is included in “other.”

The requested info is below.

Payer Mix	Percentage by Revenue	Percentage by Patient
Medicare	50.5%	50.5%
Medicaid	25.8%	25.8%
Commercial/ Other Government (L&I, VA, etc.)	21.8%	21.8%
Self-Pay	1.9%	1.9%
Charity Care		
Other Payers (please list)		
Total	100%	100%

13. If this project proposes the addition of beds to an existing facility, provide the historical payer mix by revenue and patients for the existing facility. The table format should be consistent with the table shown above.

This project does not propose the addition of beds to an existing facility.

14. Provide a listing of all new equipment proposed for this project. The list should include estimated costs for the equipment. If no new equipment is required, explain.

No new equipment is proposed. Harbor has been operating an emergency PCI program since 2019. No additional equipment is needed for elective cases.

15. Identify the source(s) of financing and start-up costs (loan, grant, gifts, etc.) and

provide supporting documentation from the source. Examples of supporting documentation include: a letter from the applicant's CFO committing to pay for the project or draft terms from a financial institution.

If this project will be debt financed through a financial institution, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.

There is no financing associated with this project.

16. Provide the most recent audited financial statements for:

- i. The applicant, and**
- ii. Any parent entity.**

Audited financials are included in Appendix 1.

Section 6

Structure and Process of Care ([WAC 246-310-230](#))

- 1. Identify all licensed healthcare facilities owned, operated, or managed by the applicant. This should include all facilities in Washington State as well as any out-of-state facilities. Include applicable license and certification numbers.**

Other than the Hospital, there are no licensed health care facilities owned, operated or managed by Harbor.

- 2. Provide a table that shows full time equivalents (FTEs) by type (e.g. physicians, management, technicians, RNs, nursing assistants, etc.) for the facility. If the facility is currently in operation, include at least the most recent full year of operation, the current year, and projections through the first three full years of operation following project completion. There should be no gaps. All FTE types should be defined.**

This CN application requests the addition of elective PCI services to Harbor's existing emergency only program. Table 1 below identifies the existing FTEs. No additional FTEs are needed to add elective PCIs. The existing staffing is capable of serving the incremental volumes.

Table 1
Current and Proposed Cath Lab Staffing

Staff Position	FTE
Registered Nurse	1
Nurse Manager	1
Cardiovascular Invasive Specialist	3

- 3. Provide the basis for the assumptions used to project the number and types of FTEs identified for this project.**

The current cath lab (providing emergency PCI only) utilizes a staffing model of 2 RNs and 3 CVIS' to staff the department weekdays 7 a.m. to 3:30 p.m. A three person call team (one RN and two CVIS') are on standby from 3:30 p.m. to 7:00 a.m. weekdays and 24 hours/day on weekends.

The existing staff has the capacity to handle the incremental elective PCI volume (provided in more detail in Section 8).

4. Identify key staff (e.g. chief of medicine, nurse manager, clinical director, etc.) by name and professional license number, if known.

The pertinent information for the cath lab staff is included in Section 8 of this application.

5. Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project.

Like nearly all hospitals in the region and nation, Harbor, has, and continues to experience workforce shortages. However, in the case of the cath lab, it is currently fully staffed, and the addition of elective volumes will make employment even more attractive; as the incremental volumes associated with elective cases will provide staff and providers with more cases to retain.

Since 2019, Harbor has also had an agreement with CardioSolution for continuous and qualified physician and non-physician staffing of the service. CardioSolution works exclusively in the cardiovascular space, and has dedicated nation-wide recruiters that find, screen, and place Cardiologists, Cath Lab RNs & Techs, Managers and Service Line Directors. More information about staff is included in Section 8 of the application.

6. For new facilities, provide a listing of ancillary and support services that will be established.

There are no new facilities. This question is not applicable.

7. For existing facilities, provide a listing of ancillary and support services already in place.

All ancillary and support services including lab, pharmacy and pre and post procedure areas are currently in place.

8. Identify whether any of the existing ancillary or support agreements are expected to change as a result of this project.

No changes to any agreements are expected.

9. If the facility is currently operating, provide a listing of healthcare facilities with which the facility has working relationships.

Please refer to Section 8 of this application for working relationships specific to PCI.

10. Identify whether any of the existing working relationships with healthcare facilities listed above would change as a result of this project.

There are no changes to any working relationships expected with the exception of the Partnering Agreement referenced in Section 8.

11. For a new facility, provide a listing of healthcare facilities with which the facility would establish working relationships.

This is not a new facility. This question is not applicable.

12. Provide an explanation of how the proposed project will promote continuity in the provision of health care services in the planning area, and not result in an unwarranted fragmentation of services.

For all of the reasons cited throughout this application, the current way Harbor is required to provide PCI is fragmented, and the addition of an elective program will mitigate the fragmentation. Today, patients in need of an elective procedure, regardless of their ability, are required to travel to Olympia or other communities. The socioeconomics of the community, and the lack of funds and/or insurance to travel mean that too many of the patients we make referrals for, despite our follow-up efforts, do not show at the referring hospital for the procedure. They often re-present at Harbor in need of an emergency procedure, which we can perform. By this time, the patient is sicker, and undergoes a duplicate procedure. The costs are also higher and health status and outcomes are potentially less than they would have been with an earlier procedure.

13. Provide an explanation of how the proposed project will have an appropriate relationship to the service area's existing health care system as required in [WAC 246-310-230\(4\)](#).

WAC 246-310-230 (4) reads:

The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system

This question was addressed in earlier questions in this section. Additional information is included in Section 8 of the application.

14. Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements.

- a. **A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a health care facility; or**
- b. **A revocation of a license to operate a healthcare facility; or**
- c. **A revocation of a license to practice as a health profession; or**
- d. **Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.**

Neither Harbor nor any practitioner associated with this application has any history related to the actions noted above.

Section 7

Cost Containment ([WAC 246-310-240](#))

1. **Identify all alternatives considered prior to submitting this project. At a minimum include a brief discussion of this project versus no project.**

The only alternative considered was the status quo; continuing with the emergency only PCI program.

2. **Provide a comparison of this project with alternatives rejected by the applicant. Include the rationale for considering this project to be superior to the rejected alternatives. Factors to consider can include, but are not limited to: patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost or operation efficiency.**

Requesting CN approval to establish an elective PCI Program is the preferred choice based on the following criteria:

- **Patient Access:** Offering elective PCI will provide better access in our community; especially when the numerous disparities and socioeconomic challenges relating to travelling to care are considered.
- **Capital Cost:** There is no capital cost as the cath lab has been in place since 2019.
- **Legal and Regulatory Restrictions:** The enforcement settlement agreement between the Department and the underperforming program in PCI Planning Area 6 removed any legal or regulatory restrictions.
- **Staffing Impacts:** As documented elsewhere in the application, there is no incremental staffing required.
- **Quality of Care:** Being able to intervene when the patient is more stable and not emergent is better care. Given that so many of our residents lack the means to travel, and return to Harbor having an acute MI, it is a less than desirable time to intervene than is scheduling an elective case locally.
- **Cost/Operational Efficiency:** Clinical staff are already in place and increased volume will result in operational efficiencies.

3. **If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):**
 1. **The costs, scope, and methods of construction and energy conservation are reasonable; and**
 2. **The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.**

This project does not involve construction.

4. **Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment, and which promote quality assurance and cost effectiveness.**

The entirety of this application describes and documents how the addition of elective PCI at Harbor will foster cost containment, quality, and cost efficiencies.

Section 8
Addendum for Hospital Projects
Percutaneous Coronary Intervention
(PCI)

[WAC 246-310-700](#) through [246-310-755](#)

Project Description

1. Is the applicant currently providing emergent PCI?

Yes, Harbor has been providing emergent PCI since 2019.

2. If no, what facilities are these patients being sent to in the most recent calendar year?

This question is not applicable.

3. If yes, provide the number of PCI's performed at the applicant hospital for the most recent three calendar years?

Table 2 below identifies the PCIs performed at Harbor during the period of 2020-YTD 2023.

Table 2
Historical Emergent PCI Volumes

Year	Volumes
2020	76
2021	71
2022	82
YTD 2023	13

Project Description

4. WAC 246-310-715(4) states:

Maintain one catheterization lab used primarily for cardiology. The lab must be a fully equipped cardiac catheterization laboratory with all appropriate devices, optimal digital imaging systems, life sustaining apparatus, intra- aortic balloon pump assist device (IABP).

Provide documentation and a discussion demonstrating that this proposal meets this requirement.

Harbor has one dedicated cardiology lab. It is fully equipped with all appropriate devices, including digital imaging and IABP.

5. Describe how this project will comply with WAC 246-310-715(5), which requires that the facility be available to perform emergent PCIs twenty-four hours a day, seven days a week in addition to scheduled PCIs?

Since 2019, the cath lab has been staffed and available to perform emergent PCI 24/7. It will continue to be so when elective PCIs are added.

Certificate of Need Review Criteria

A. Need

6. The department will use the posted need forecasting methodology available as of the application submission date. Confirm that you understand this methodology will be used in reviewing your project.

Yes, Harbor understands that the posted need forecasting methodology, which identifies the need for one additional program in PCI Planning Area 6, will be used in the review of this CN.

7. **Provide the projected number of adult elective PCIs starting in the implementation calendar year and following the initiation of the service, including at least three full calendar years. All new elective PCI programs must comply with the state of Washington annual PCI volume standard of 200 (two hundred) by the end of year three. WAC 246-310-715(2)**

Harbor estimates that it will begin performing elective PCIs on January 1, 2024. The estimated volumes for the first three years are included in Table 3.

Table 3
Projected PCI Volumes (2024-2026)

Type	2024	2025	2026
Emergent	94	112	128
Scheduled	62	75	85
Total	156	187	213

8. **WAC 246-310-720(2) states:**
The department shall only grant a certificate of need to new programs within the identified planning area if:
(a) The state need forecasting methodology projects unmet volumes sufficient to establish one or more programs within a planning area; and
(b) All existing PCI programs in that planning area are meeting or exceeding the minimum volume standard.

Provided documentation that this standard is met for the planning area.

The Department's posted methodology identifies the need for one additional program in PCI Planning Area 6. In terms of all providers meeting or exceeding the minimum volume standard, this standard is not met. However, as noted in earlier sections of this application, there are two providers of PCI in Planning Area 6. After more than 12 years of non-compliance, in February of 2022, the Program entered into a settlement agreement with one of the providers, due to its low volumes and inability to meet WAC requirements. The settlement noted, in part, that:

The Department may grant a CN to a new elective PCI program in Planning Area #6... so long as the CN application for that new program is filed within the term of this agreement identified in paragraph 5, or within three years follow execution of this Agreement, which is later. 5

Based on this settlement, Harbor understands that the Program will accept and can approve a project from Harbor under the current rules in the upcoming cycle; assuming that Harbor meets all other general CN requirements as well as specific PCI requirements.

B. Financial Feasibility

- 9. Provide revenue and expense statements for the PCI cost center that show the implementation calendar year and three calendar years following initiation of the service.**

Revenue and expense statements for the cost center are included as Exhibit 6. Please note that the initial year (2024) is a full calendar year. As such Harbor provided the pro formas for the period of 2024-2026. Should the Program want an additional year, please advise in screening.

- 10. Provide pro forma revenue and expense statements for the hospital with the PCI project that show the implementation year and three calendar years following initiation of the service.**

The requested revenue and expense statements for the Hospital with the project are included as Exhibit 6. Please note that the initial year (2024) is a full calendar year. As such, Harbor provided the pro formas for the period of 2024-2026. Should the Program want an additional year, please advise in screening.

- 11. Provide pro forma revenue and expense statements for the hospital without the proposed PCI project that show the same calendar years as provided in response to the two questions above.**

Revenue and expense statements for the Hospital without the proposed project are included as Exhibit 6. Please note that the initial year (2024) is a full calendar year. As such Harbor provided the pro formas for the period of 2024-2026. Should the Program want an additional year, please advise in screening.

- 12. Provide the proposed payer mix specific to the proposed unit. If the hospital is already providing emergent PCIs, also provide the current unit's payer mix for reference.**

The table below provides the payer mix. Based on the payer mix for the community at large, Harbor has assumed no change when the elective program is added.

Revenue Source	Emergent PCI Program (if applicable)	Proposed PCI Program
Medicare	50.62%	50.62%
Medicaid	14.25%	14.25%
Commercial/Other Insurance including other government (L&I, VA, etc.)	33.37%	33.37%
Self-Pay	1.76%	1.76%
Charity Care		
Other Payers (please list)	NA	NA
Total	100.0%	100.0%

13. If there is no estimated capital expenditure for this project, explain why.

There is no capital expenditure because Harbor has been operating an emergent PCI program since 2019. The 2019 purchase included all appropriate devices, including digital imaging and IABP.

c. Structure and Process of Care

14. Provide the name and professional license number of the current or proposed medical director. If not already disclosed, clarify whether the medical director is an employee or under contract.

The Medical Director is Dr. Sumeet Sachdev, professional license # MD60789987. The Medical Director is under agreement with CardioSolution.

15. If the medical director is/will be an employee rather than under contract, provide the medical director's job description.

This question is not applicable.

16. If the medical director is/will be under contract rather an employee, provide the medical director contract.

The Medical Director agreement is part of a larger Master Services Agreement with CardioSolution, LLC. The Agreement is included in Exhibit 8.

17. Provide a list of all credentialed staff proposed for this service (including the catheterization lab staff) including their names, license numbers, and specialties. WAC 246-310-715(4)

This is an existing facility, and proposed staff is the same as the current staff. The information is provided in response to the question below.

18. For existing facilities, provide names and professional license numbers for current credentialed staff (including the catheterization lab staff) including their names, license numbers, and specialties. WAC 246-310-715(4).

The requested information is included in the Table 4 below:

**Table 4
Current Credentialed Staff**

Name	License/Certification	License #
Richard Snyder	RN	RN60544216
Glenda Parrish	RN	RN61146965
Cynthia Sharp	RN	RN61247454
Leigh Ann Downing	RN	RN60374564
Mitchel McGehee	CVIS	IS60544679
Lisa Kassa	CVIS	IS60485241
Mike Spangler	CVIS	IS61393731

19. Provide any unit-specific policies or guidelines for the proposed PCI service.

Cath lab specific policies are included in Exhibit 9.

20. Submit a detailed analysis of the impact the proposed adult elective PCI services will have on the Cardiovascular Disease and Interventional Cardiology Fellowship Training programs at the University of Washington Medical Center. WAC 246-310- 715(1)

Details on the expected impact of the of the proposed adult elective PCI services on the Cardiovascular Disease Interventional Cardiology Fellowship Training programs at the University of Washington Medical Center is included in the letter sent to Larry Dean, MD, the founding Director of the UW Medicine Regional Heart Center. This letter is included as Exhibit 10. The record should reflect that in Harbor's 2020 PCI CN application, Dr. Dean noted that the impact was expected to be minimal. Based on the data, we expect the same response in 2023.

21. Provide discussion and any documentation that the new PCI program would not reduce current volumes below the hospital standard at the University of Washington fellowship training program. WAC 246-310-715(1)

This information is provided in Exhibit 10.

22. Provide a copy of any response from the University of Washington Medical Center.

A response has not yet been received from the University of Washington Medical Center. Harbor Regional Health will provide the program with any response received during the application and screening period.

23. Provide documentation that the physicians who would perform adult elective PCI procedures at this hospital have performed a minimum of fifty PCI procedures per year for the previous three years prior to submission of this application. WAC 246- 310-725.

Table 5 includes the names and historical PCI volumes of the physicians who will perform adult elective PCI procedures at Harbor. Exhibit 11 includes an attestation/documentation from CardioSolution confirming these volumes.

**Table 5
Historical Physician Volumes**

	2019	2020	2022
Arthur Lee, MD	79	107	82
Sumeet Sachdev, MD	55	72	69

Other CardioSolution cardiologists currently do and will continue to support the 24/7 emergency PCI program at Harbor.

24. Provide projected procedure volumes by physician for each of the physicians listed in the previous question.

Dr. Lee and Dr. Sachdev will support the elective PCI program. Their projected elective volumes are included in Table 6 below.

Table 6
Projected Elective PCI Volumes by Physician

Physician	2024	2025	2026
Arthur Lee, MD	32	40	45
Sumeet Sachdev, MD	30	35	40
Total Elective PCI Procedures	62	75	85
Total Emergent PCI Procedures	94	112	128
Total PCIs	156	187	213

The emergent PCI program is currently supported by and will continue to be supported by the additional cardiologists included in Table 7 below.

Table 7
Harbor Regional Health Emergent PCI Program Cardiologists

Physician	License #
Robert Emerick, MD	MD00040562
Steven Goldberg, MD	MD00038729
John Golden, MD	MD61120268
Kenneth Igbalode, MD	MD61041046
Ralph Kunkel, MD	MD00020829
Christopher Larson, MD	OP61203154
Kenta Nakamura, MD	MD60640463
William Rowe, MD	MD00025511

25. Provide a discussion on how the projected PCI volumes will be sufficient to assure that all physicians staffing the program will be able to meet volume standards of fifty PCIs per year. WAC 246-310-715(2)

The physicians supporting the elective program are provided under agreement with CardioSolution. As identified above, these physicians are already meeting the volume standard of fifty PCIs per year and their projected volumes, just from the elective PCI program at Harbor, are more than the minimum volume standard.

- 26. Submit a plan detailing how the applicant will effectively recruit and staff the new program with qualified nurses, catheterization laboratory technicians, and interventional cardiologists without negatively affecting existing staffing at PCI programs in the same planning area. WAC 246-310-715(3)**

Harbor currently operates a fully staffed cardiac catheterization laboratory and utilizes the services of CardioSolution LLC to provide both Registered Nurses (RN) and Cardiovascular Invasive Specialists (CVIS) to staff the program. We will continue to do so with the addition of the elective cases.

- 27. Provide documentation that the catheterization lab will be staffed by qualified, experienced nursing and technical staff with documented competencies in the treatment of acutely ill patients. The answer to this question should demonstrate compliance with WAC 246-310-730.**

Existing cath lab staff include RNs and Cardiovascular Invasive Specialists (CVIS). All RNs have critical care experience or equivalent. Annual competencies demonstrate skill levels appropriate for the environment. See Exhibit 12 for relevant job descriptions and competency checklists. Additionally, Harbor maintains qualified staff in all pre and post procedure areas.

- 28. WAC 246-310-735 requires a partnering agreement to include specific information. Provide a copy of the agreement.**

The partnering agreement with Providence St. Peter Hospital in Olympia is included in Exhibit 13.

29. Identify where, within this agreement or any other agreement provided in this application, numbers (1) through (13) below are addressed.

- (1) *Coordination between the nonsurgical hospital and surgical hospital's availability of surgical teams and operating rooms. The hospital with on-site surgical services is not required to maintain an available surgical suite twenty-four hours, seven days a week.***

This requirement is addressed under 3.1 Coordination: The Transferring Hospital and the Receiving Hospital shall coordinate availability of surgical teams and operating rooms. The Receiving Hospital is not required to maintain an available surgical site 24 hours, seven days a week.

- (2) *Assurance the backup surgical hospital can provide cardiac surgery during all hours that elective PCIs are being performed at the applicant hospital.***

This requirement is addressed under the following sections:

1.5. Hours of Operation: The Transferring Hospital shall keep the Receiving Hospital informed of its hours of operation of elective PCI.

2.1 Acceptance of Transfers: Pursuant to existing admission policies and procedures, the Receiving Hospital agrees to accept all patients referred by the Transferring Hospital under this agreement. In the event of capacity issue or if in the best interest of the patient, a transfer to a higher level of care may be considered.

2.2 The Receiving Hospital agrees to accept all patients referred by the Transferring Hospital under this agreement. In the event of capacity issue or if in the best interest of the patient, a transfer to a higher level of care may be considered.

2.3 Hours of Operation. The Receiving Hospital shall ensure that it is available to provide cardiac surgery during the hours that elective PCIs are performed at the Transferring Hospital.

3.1 Coordination: The Transferring Hospital and the Receiving Hospital shall coordinate availability of surgical teams and operating rooms. The Receiving Hospital is not required to maintain an available surgical site 24 hours, seven days a week.

- (3) *Transfer of all clinical data, including images and videos, with the patient to the backup surgical hospital.***

This requirement is addressed under 1.4. Transfer of Clinical Data: *The Transferring Hospital shall transfer all clinical data, including images and videos, with the patient to the Receiving Hospital.*

- (4) *Communication between Physicians. The Transferring Hospital will coordinate communication by the physician(s) performing the elective PCI to the Receiving Hospital cardiac surgeon(s) about the clinical reasons for urgent transfer and the patient's clinical condition.***

This requirement is addressed under 1.3. Communication between Physicians: *The Transferring Hospital will coordinate communication by the physician(s) performing the elective PCI to the Receiving Hospital cardiac surgeon(s) about the clinical reasons for urgent transfer and the patient's clinical condition.*

- (5) *Acceptance of all referred patients by the backup surgical hospital.***

This requirement is addressed under 2.2: *The Receiving Hospital agrees to accept all patients referred by the Transferring Hospital under this agreement. In the event of capacity issue or if in the best interest of the patient, a transfer to a higher level of care may be considered.*

- (6) *The applicant hospital's mode of emergency transport for patients requiring urgent transfer. The hospital must have a signed transportation agreement with a vendor who will expeditiously transport by air or land all patients who experience complications during elective PCIs that require transfer to a backup hospital with on-site cardiac surgery.***

This requirement is addressed under 1.2. Emergency Transport: *The Transferring Hospital shall arrange for appropriate and safe transportation to the Receiving Hospital. The Transferring Hospital will stabilize the patient to the degree possible prior to transfer to avoid potential harm during transfer. The Transferring Hospital shall have an agreement in place with a transport vendor. The emergency transport staff shall be advanced cardiac life support certified and have skills and training necessary to monitor and treat the patient during transport, including management of an intra-aortic balloon pump (IABP). The emergency transport must commence within twenty (20) minutes of the initial indication of a complication.*

This requirement is also addressed through the emergency services agreement included in Exhibit 14.

(7) *Emergency transportation beginning within twenty minutes of the initial identification of a complication.*

This requirement is addressed under 1.2. Emergency Transport: *The Transferring Hospital shall arrange for appropriate and safe transportation to the Receiving Hospital. The Transferring Hospital will stabilize the patient to the degree possible prior to transfer to avoid potential harm during transfer. The Transferring Hospital shall have an agreement in place with a transport vendor. The emergency transport staff shall be advanced cardiac life support certified and have skills and training necessary to monitor and treat the patient during transport, including management of an intra-aortic balloon pump (IABP). The emergency transport must commence within twenty (20) minutes of the initial indication of a complication.*

This requirement is also addressed through the emergency services agreement included in Exhibit 14.

(8) *Evidence that the emergency transport staff are certified. These staff must be advanced cardiac life support (ACLS) certified and have the skills, experience, and equipment to monitor and treat the patient en route and to manage an intra-aortic balloon pump (IABP).*

This requirement is addressed under 1.2. Emergency Transport: *The Transferring Hospital shall arrange for appropriate and safe transportation to the Receiving Hospital. The Transferring Hospital will stabilize the patient to the degree possible prior to transfer to avoid potential harm during transfer. The Transferring Hospital shall have an agreement in place with a transport vendor. The emergency transport staff shall be advanced cardiac life support certified and have skills and training necessary to monitor and treat the patient during transport, including management of an intra-aortic balloon pump (IABP). The emergency transport must commence within twenty (20) minutes of the initial indication of a complication.*

This requirement is also addressed through the emergency services agreement included in Exhibit 14.

(9) *The hospital documenting the transportation time from the decision to transfer the patient with an elective PCI complication to arrival in the operating room of the backup hospital. Transportation time must be less than one hundred twenty minutes.*

This requirement is addressed under 1.6. Documentation of Transfer: *The Transferring Hospital shall document the reason(s) for recommending the transfer in the patient's medical record, a copy to be sent with the patient to the Receiving Hospital. The Transferring Hospital shall document the transportation time from the decision to transfer the patient with an elective PCI complication to arrival in the operating room of the Receiving Hospital. Transportation time must be less than 120 minutes.*

(10) *At least two annual timed emergency transportation drills with outcomes reported to the hospital's quality assurance program.*

This requirement is addressed under 1.7. Emergency Transportation Drills: *The Transferring Hospital shall conduct at least two annual timed emergency drills with outcomes reported to the hospital's quality assurance program.*

(11) *Patient signed informed consent for adult elective (and emergent) PCIs. Consent forms must explicitly communicate to the patients that the intervention is being performed without on- site surgery backup and address risks related to transfer, the risk of urgent surgery, and the established emergency transfer agreements.*

This requirement is addressed under 1.1. Informed Consent: *The Transferring Hospital shall secure the patient's signed informed consent for PCI. The consent shall indicate that the Transferring Hospital does not provide on-site surgical backup and shall address the risks related to transfer, the risk of urgent surgery, and the established emergency transfer agreements.*

This requirement is also addressed through the informed consent form provided in Exhibit 15.

(12) *Conferences between representatives from the heart surgery program(s) and the elective coronary intervention program. These conferences must be held at least quarterly, in which a significant number of preoperative and post-operative cases are reviewed, including all transport cases.*

This requirement is addressed under 3.3 Conferences: *Conferences between representatives from the heart surgery program and the elective coronary intervention program must be held at least quarterly. They must review a significant number of preoperative and post-operative cases, including all transport cases.*

(13) Addressing peak volume periods (such as joint agreements with other programs, the capacity to temporarily increase staffing, etc.).

This requirement is addressed under 3.2 Peak Volume Periods: *The Transferring Hospital and the Receiving Hospital shall address peak volume periods (such as joint agreements with other programs, the capacity to temporarily increase staffing, etc.).*

30. WAC 246-310-740 requires this document to include specific information. Provide a copy of the agreement.

The required Quality document is included in Exhibit 16.

31. Identify where, within the agreement, numbers (1) through (4) below are addressed.

The requirements in WAC 246-310-740 are addressed in the Cardiac Cath Lab Policy & Procedure included in Exhibit 16. The specific purpose of this policy is to establish the quality assurance review and reporting process for all cath lab procedures.

(1) A process for ongoing review of the outcomes of adult elective PCIs. Outcomes must be benchmarked against state or national quality of care indicators for elective PCIs.

This requirement is addressed under II. Outcomes Review:

A. Procedural outcomes will be benchmarked against state and national quality care indicators for all PCIs.

1. Hospital will report data to American College of Cardiology National Cardiovascular Database (NCDR) Cath PCI Registry.

2. Hospital will report outcomes data to Washington State Clinical Outcomes Assessment Program (COAP).

B. Outcomes data reports will be reviewed by Cardiac Quality Assurance Committee on a quarterly basis. An action plan will be developed for any outcome falling below the fiftieth percentile on the NCDR PCI data report.

C. Outcomes measures will include:

1. PCI in hospital risk adjusted mortality

2. Composite: Guideline medications prescribed at discharge

3. PCI in-hospital risk standardized bleeding

4. PCI procedure with positive stress or imaging study

5. Median time to immediate PCI (pts with STEMI)

6. Emergency/salvage CABG post PCI
7. Intra/post procedure stroke
8. Composite: Major adverse events
9. Access site injury or major bleeding
10. PCI in-hospital risk adjusted acute kidney injury
11. Radiation dose (PCI procedure with or without dx cath)
12. Cardiac Rehabilitation referral
13. PCI Appropriate Use Criteria

(2) A system for patient selection that results in outcomes that are equal to or better than the benchmark standards in the applicant's plan.

This requirement is addressed under II. Outcomes Review (see response to Question 1 – specifically C13, PCI Appropriate Use Criteria.)

(3) A process for formalized case reviews with partnering surgical backup hospital(s) of preoperative and post-operative elective PCI cases, including all transferred cases.

This requirement is addressed under: I. Quality Assurance Committee:

- A. Cardiac Quality Assurance Committee will meet quarterly to review process and outcomes issues.
- B. Quality Assurance Committee shall consist of CNO, CMO, Cardiology Medical Director, Cath Lab Director, **Clinical representative of Transfer agreement Hospital**, ED Medical Director, and ICU Medical Director. CardioSolution CMO will be available as needed.
- C. Committee shall review all benchmark data including ACC NCDR PCI, COAP, and Cath Lab complications.
- D. Committee shall review all PCI patients sent to Transfer Hospital as required in WAC 2546-310-740.3. Review will be conducted using data uploaded to the Ambria secure imaging website.
- E. Cardiac Quality Assurance Committee shall report to Hospital Quality Assurance Committee.

This requirement is also addressed through the partnering agreement included in Exhibit 13, specifically 3.3 Conferences: *Conferences between representatives from the heart surgery program and the elective coronary intervention program must be held at least quarterly. They must review a significant number of preoperative and post-operative cases, including all transport cases.*

(4) A description of the hospital's cardiac catheterization laboratory and elective PCI quality assurance reporting processes for information requested by the department or the department's designee. The department of health does not intend to require duplicative reporting of information.

This requirement is addressed under II. Outcomes Review:

A. Procedural outcomes will be benchmarked against state and national quality care indicators for all PCIs.

1. Hospital will report data to American College of Cardiology National Cardiovascular Database (NCDR) Cath PCI Registry.

2. Hospital will report outcomes data to Washington State Clinical Outcomes Assessment Program (COAP).

Exhibit 1
Organizational Structure

Organizational Structure

Board of Directors

President/Chief Executive Officer
Tom Jensen

Executive Director
Harbor Medical Group
Elizabeth Tschimperle

Chief Financial Officer
Niall Foley

Chief Medical Officer
Anne Marie Wong, MD

Chief Nursing Officer
Dori Unterseher

Administration

Ops. Mgr – Vacant

RHC Clinics

EC - Highland Family
Medicine
EC - Internal Medicine
EC - Pediatrics
Hoq - Family Medicine
Hoq - OB/GYN
Monte - Family Medicine

General / Specialty

Anesthesia
Cardiology
Chemical Dependency
Gastroenterology
GH Orthopedics
GH Surgeons
Hospitalists
Radiology
Urology
Trauma

Controller
Angela Thiery

Accounting – Diana Thompson

Revenue Cycle
Kevin Vålen

Health Information Mgmt
Jina Gardiner
Registration
Laura Cinert

Supply Chain
Cynthia Fesagaiga

Information Technology
Brad Wallace

Care Transitions
Phil Royer

CDMP
Social Services
Utilization Review

**Quality, Risk,
Compliance**
Vacant

Medical Staff Services
Juanita Howell
Patient Advocate
Bonnie Mollett

Diagnostic Imaging
Randy Holeman

Supervisor Paige Mellon-Jackson

Human Resources
Julie Feller

Education - Vacant
Payroll – Debbie Warring
Volunteers – Karen Shafer

Laboratory
Alyson Weiss

Supervisor Vacant

Plant Services
Dwayne Lunde

Biomed
EVS and Shuttle – Megan Souza
Nutrition – RaeAnn Brown
Security

Public Relations
Chris Majors

GHCH Foundation

Rehab Visions
Chris Jensen

Cardiac Cath Lab
Glenda Parrish

Cardiopulmonary
Vacant

Cardiac Rehab

HarborCrest
Tracie Moen
Cristen Rogers

Critical Care Unit
Shannon Johnson

Ambulatory Infusion

Emergency Dept
Nicole Simons

Family Birth Center
Alice Skupnick

Wound Healing
Vacant

Infection Control
Melanie Brandt

Medical/Pediatric Unit
Shannon Johnson

Surgical Unit
Shannon Johnson

Med/Peds/Surg Clinical Sup.
Cassie Bosarge
Telemetry

Nursing Support
Dori Unterseher

House Supervisors
Staffing Office

Surgical Services
John Cribbs

Pharmacy
Wendy Cahill

Dietitian

Last Revised: 02-06-23

Exhibit 2
Letter of Intent

January 31, 2023

Eric Hernandez, Program Manager
Certificate of Need Program
Department of Health
111 Israel Road Southeast
Tumwater, WA 98501
Via email: FSLCON@DOH.WA.GOV; eric.hernandez@doh.wa.gov

Dear Mr. Hernandez:

In accordance with WAC 246-310-080, Grays Harbor Public Hospital District No. 2, dba Harbor Regional Health, here within submits a letter of intent proposing to establish an elective PCI program.

1. A Description of the Extent of Services Proposed:

Harbor Regional Health intends to establish an elective PCI Program.

2. Estimated Cost of the Proposed Project:

There is no capital expenditure.

3. Description of the Service Area:

The primary service area is the WAC defined PCI Planning Area 6.

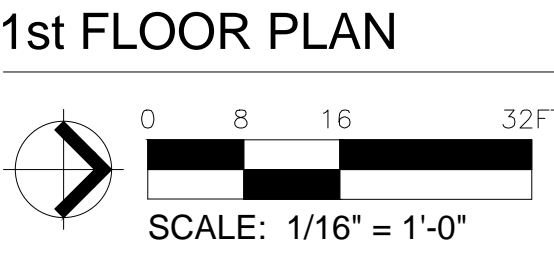
Please contact me directly with any questions.

Sincerely,



Tom Jensen,
Chief Executive Officer
tjensen@ghcares.org

Exhibit 3
Cath Lab Drawings



1st FLOOR AREA		LEGEND
1,212	SF	VACANT
1,901	SF	CARDIAC REHAB
5,797	SF	IMAGING
1,012	SF	NUCLEAR MEDICINE
730	SF	CT
9,563	SF	EMERGENCY DEPARTMENT
2,492	SF	SHORT STAY
335	SF	SURGERY
401	SF	LABORATORY
807	SF	PHYSICIAN SUPPORT
348	SF	ENVIRONMENTAL SVC.
435	SF	INFORMATION SYSTEMS
6,516	SF	ADMINISTRATION
571	SF	ADMITTING
974	SF	VOLUNTEER SERVICES
14,519	SF	COMMON AREAS
2,772	SF	PLANT
50,385	NSF	SUBTOTAL
4,752	SF	NET/GROSS CONVERSION
55,137	GSF	TOTAL

Exhibit 4
Patient Origin

Harbor Regional Health Patient Origin

Zip Code	County	City	Discharges	% of Total Discharges
98520	Grays Harbor	Aberdeen	789	33.04%
98550	Grays Harbor	Hoquiam	491	20.56%
98569	Grays Harbor	Ocean Shores	275	11.52%
98563	Grays Harbor	Montesano	113	4.73%
98595	Grays Harbor	Westport	109	4.56%
98587	Grays Harbor	Taholah	78	3.27%
98537	Grays Harbor	Cosmopolis	56	2.35%
98547	Grays Harbor	Grayland	36	1.51%
98541	Grays Harbor	Elma	34	1.42%
98577	Pacific	Raymond	28	1.17%
98404	Pierce	Tacoma	28	1.17%
98584	Mason	Shelton	23	0.96%
98535	Grays Harbor	Copalis Beach	17	0.71%
98513	Thurston	Olympia	15	0.63%
98331	Clallam	Forks	14	0.59%
98586	Pacific	South Bend	14	0.59%
98571	Grays Harbor	Pacific Beach	11	0.46%
98590	Pacific	Tokeland	10	0.42%
98552	Grays Harbor	Humptulips	9	0.38%
98092	King	Auburn	9	0.38%
98557	Grays Harbor	McCleary	8	0.34%
98526	Grays Harbor	Amanda Park	8	0.34%
98444	Pierce	Tacoma	8	0.34%
98566	Grays Harbor	Neilton	6	0.25%
98392	Kitsap	Suquamish	5	0.21%
98370	Kitsap	Poulsbo	5	0.21%
98575	Grays Harbor	Quinault	4	0.17%

Zip Code	County	City	Discharges	% of Total Discharges
98562	Grays Harbor	Moclips	4	0.17%
98148	King	Seattle	4	0.17%
98443	Pierce	Tacoma	4	0.17%
98424	Pierce	Tacoma	4	0.17%
98372	Pierce	Puyallup	4	0.17%
98579	Thurston	Rochester	4	0.17%
98501	Thurston	Olympia	4	0.17%
98568	Grays Harbor	Oakville	3	0.13%
98366	Kitsap	Port Orchard	3	0.13%
98312	Kitsap	Bremerton	3	0.13%
98422	Pierce	Tacoma	3	0.13%
98405	Pierce	Tacoma	3	0.13%
98338	Pierce	Graham	3	0.13%
98272	Snohomish	Monroe	3	0.13%
98223	Snohomish	Arlington	3	0.13%
98270	Snohomish	Marysville	3	0.13%
98201	Snohomish	Everett	3	0.13%
98012	Snohomish	Bothell	3	0.13%
99337	Benton	Kennewick	2	0.08%
98363	Clallam	Port Angeles	2	0.08%
98362	Clallam	Port Angeles	2	0.08%
98583	Grays Harbor	Satsop	2	0.08%
98536	Grays Harbor	Copalis Crossing	2	0.08%
98178	King	Seattle	2	0.08%
98117	King	Seattle	2	0.08%
98022	King	Enumclaw	2	0.08%
98337	Kitsap	Bremerton	2	0.08%

Zip Code	County	City	Discharges	% of Total Discharges
98310	Kitsap	Bremerton	2	0.08%
98532	Lewis	Chehalis	2	0.08%
98531	Lewis	Centralia	2	0.08%
98588	Mason	Tahuya	2	0.08%
98631	Pacific	Long Beach	2	0.08%
98387	Pierce	Spanaway	2	0.08%
98498	Pierce	Lakewood	2	0.08%
98466	Pierce	Tacoma	2	0.08%
98446	Pierce	Tacoma	2	0.08%
98445	Pierce	Tacoma	2	0.08%
95207	San Joaquin	Stockton	2	0.08%
98502	Thurston	Olympia	2	0.08%
98512	Thurston	Olympia	2	0.08%
98511	Thurston	Tumwater	2	0.08%
98508	Thurston	Olympia	2	0.08%
98506	Thurston	Olympia	2	0.08%
99350	Benton	Prosser	1	0.04%
99336	Benton	Kennewick	1	0.04%
97456	Benton	Monroe	1	0.04%
98357	Clallam	Neah Bay	1	0.04%
98684	Clark	Vancouver	1	0.04%
98682	Clark	Vancouver	1	0.04%
98661	Clark	Vancouver	1	0.04%
97146	Clatsop	Warrenton	1	0.04%
97138	Clatsop	Seaside	1	0.04%
98626	Cowlitz	Kelso	1	0.04%
98611	Cowlitz	Castle Rock	1	0.04%

Zip Code	County	City	Discharges	% of Total Discharges
97471	Douglas	Roseburg	1	0.04%
59919	Flathead	Hungry Horse	1	0.04%
99301	Franklin	Pasco	1	0.04%
93705	Fresno	Fresno	1	0.04%
98837	Grant	Moses Lake	1	0.04%
42420	Henderson	Henderson	1	0.04%
99801	Juneau	Juneau	1	0.04%
78006	Kendall	Boerne	1	0.04%
98155	King	Seattle	1	0.04%
98146	King	Seattle	1	0.04%
98126	King	Seattle	1	0.04%
98124	King	Seattle	1	0.04%
98122	King	Seattle	1	0.04%
98109	King	Seattle	1	0.04%
98108	King	Seattle	1	0.04%
98104	King	Seattle	1	0.04%
98103	King	Seattle	1	0.04%
98101	King	Seattle	1	0.04%
98038	King	Maple Valley	1	0.04%
98023	King	Federal Way	1	0.04%
98003	King	Federal Way	1	0.04%
98380	Kitsap	Seabeck	1	0.04%
98367	Kitsap	Port Orchard	1	0.04%
98311	Kitsap	Bremerton	1	0.04%
98110	Kitsap	Bainbridge Island	1	0.04%
98922	Kittitas	Cle Elum	1	0.04%
98582	Lewis	Salkum	1	0.04%

Zip Code	County	City	Discharges	% of Total Discharges
91602	Los Angeles	North Hollywood	1	0.04%
97914	Malheur	Ontario	1	0.04%
98528	Mason	Belfair	1	0.04%
33042	Monroe	Summerland Key	1	0.04%
97230	Multnomah	Portland	1	0.04%
97219	Multnomah	Portland	1	0.04%
98640	Pacific	Ocean Park	1	0.04%
98527	Pacific	Bay Center	1	0.04%
98467	Pierce	University Place	1	0.04%
98418	Pierce	Tacoma	1	0.04%
98409	Pierce	Tacoma	1	0.04%
98407	Pierce	Tacoma	1	0.04%
98390	Pierce	Sumner	1	0.04%
98374	Pierce	Puyallup	1	0.04%
98373	Pierce	Puyallup	1	0.04%
98371	Pierce	Puyallup	1	0.04%
98332	Pierce	Gig Harbor	1	0.04%
98321	Pierce	Buckley	1	0.04%
92592	Riverside	Temecula	1	0.04%
98296	Snohomish	Snohomish	1	0.04%
99027	Spokane	Otis Orchards	1	0.04%
99022	Spokane	Medical Lake	1	0.04%
99021	Spokane	Mead	1	0.04%
98516	Thurston	Olympia	1	0.04%
98507	Thurston	Olympia	1	0.04%
98503	Thurston	Lacey	1	0.04%
97801	Umatilla	Pendleton	1	0.04%

Zip Code	County	City	Discharges	% of Total Discharges
99362	Walla Walla	Walla Walla	1	0.04%
97140	Washington	Sherwood	1	0.04%
98295	Whatcom	Sumas	1	0.04%
98264	Whatcom	Lynden	1	0.04%
98225	Whatcom	Bellingham	1	0.04%
98908	Yakima	Yakima	1	0.04%
98903	Yakima	Yakima	1	0.04%
98902	Yakima	Yakima	1	0.04%
98901	Yakima	Yakima	1	0.04%
Total			2,388	100.00%

Exhibit 5
Hospital Policies



HOSPITAL POLICY AND PROCEDURE

Title: Admission of a Patient

Number: A724

Effective Date: 03-19-14

Revise Date:

Review Date (no revisions): 11/10/17, 03-05-19

PURPOSE

To define the admitting policy for patients of Grays Harbor Community Hospital.

POLICY

Hospital services shall be made available to all persons, without prejudice, and shall be limited only by bed availability. The admission of patients when there are limited beds available in the community shall be based on a system which gives priority to critically ill patients.

- A. Hospital Personnel will treat all patients and visitors receiving services from or participating in other programs of Grays Harbor Community Hospital and its affiliated clinics with equality in a welcoming manner that is free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law. (Refer to policy A723 Patient Non-Discrimination).
- B. Patients shall be admitted to the hospital only upon the orders and under the care of a member of the medical staff who is lawfully authorized to diagnose, prescribe and treat patients.
- C. The hospital will inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. All patients who are registered will be offered the Patient Rights and Responsibilities brochure. (Refer to policy A715 Patient Rights/Patient Responsibilities for a full description).
- D. The hospital's goal, based on a reverence for life that honors the individuality and particularity of every person, is to provide compassionate care and to effectively alleviate pain and suffering especially at the end of life. We are committed to providing care that honors the personhood, dignity and value of dying persons. (Refer to A713 Advanced Directive; *Patient Rights for End-of-Life Treatment*).
 - GHCH shall offer basic information about advance directives to every registered patient and make available educational materials including sample forms to patients and the general public upon request.
 - The hospital will honor the treatment decisions of every patient and will advise a patient or his/her agent when we are unable to honor his/her advance directive. GHCH shall make a reasonable effort to obtain copies of Advance Directives when patients register for services.
 - GHCH will not discriminate against any person seeking medical care based on the existence or lack of existence of an advance directive.

- E. Recognizing the right of patients to be informed of their health status, to be involved in care planning and treatment, and to be able to request or refuse treatment, a variety of consent forms will be used to facilitate all patients' participation. The patient's signature, or other person legally authorized to provide consent on behalf of a patient, will be obtained as an indicator that the patient was involved in the decision making process, having been informed of the patient's health status, diagnosis and prognosis. (Refer to policy A406 Consent for Health Care).
- F. A Notice of Privacy Practices Pamphlet is provided to every patient each time s/he is registered for services. This pamphlet informs the patient of their Privacy Rights and our hospital's Privacy Practices. (Refer to policy REG-060 Patient Privacy Rights).
- G. Through the Medical Financial Assistance (MFA) program, the hospital provides financial assistance to facilitate access to care for vulnerable populations. This includes offering medical financial assistance to uninsured and insured low income patients where the ability to pay for medical services acts as a barrier to accessing medically necessary care. Information about the MFA program will be widely available to all patients seeking care, to all GHCH staff and providers within the care delivery process, and to all employees who may need to discuss patient financial responsibility. (Refer to policy PA-501 Medical Financial Assistance (MFA) a.k.a. Charity Care).

Reviewing Bodies: Registration Director

Authored by:

Chief Nursing Officer

Date

Authenticated by:

President/CEO

Date



PATIENT ACCOUNTS - POLICY

Title: Charity Care Policy

Number: PA 501

Effective Date: 08/12/2011

Revised Date: 11/8/2016, 7/30/2018, 5/10/2022

Review Date (no revisions):

PURPOSE

To provide, within reasonable limitations and the financial ability of the Hospital, critical services to patients who do not have sufficient financial resources to pay for services rendered or to be rendered. The Charity Care policy provides for evaluation, consistent with the criteria stated below, of financial need of the patient or responsible party for the patient.

POLICY

In recognition of the need of individuals with limited financial resources to obtain certain critical health care services, Grays Harbor County Public Hospital District No. 2 d/b/a Harbor Regional Health herewith adopts a Charity Care Program for Harbor Regional Health.

Charity Care will be granted to all eligible persons regardless of age, race, color, religion, sex, sexual orientation or national origin in accordance with WAC Chapter 246-453, RCW 70.170, and SHB1616.

ELIGIBILITY REQUIREMENTS

- I. Patient with income within Harbor Regional Health's Poverty Guidelines (refer to Hospital's Sliding Fee Schedule A) which are based on the Federal Poverty Guideline.

CRITERIA FOR EVALUATION:

Requests for charity care will be accepted from any source. Typically that will be physicians, community or religious groups, social services, financial services personnel, or the patient. If the hospital becomes aware of factors which might qualify the patient for charity care under this policy, it will advise the patient of this potential and make an initial determination.

- I. The patient indicates and appropriately and adequately demonstrates an inability to pay for services rendered or to be rendered. For all purposes of this Policy and the Program, all references to "patient" shall include, as may be applicable, the responsible party for the patient. The Program recognizes, addresses, and is limited to the needs of patients who are "indigent persons" as defined by WAC 246-453-010(4), which may include those who need assistance with medical bills due to temporary or permanent disability or inability to work as a result of catastrophic illness or injury.

Under no circumstances will the Hospital deny access to emergency care to any individuals based on an inability to pay and/or inability to qualify for charity care.

- II. Pursuant to WAC 246-453-010(7), services covered under the Program shall include only appropriate hospital-based or participating physician practice medical services. "Appropriate hospital-based medical services" shall mean those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate or prevent the worsening of conditions that

endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. For this purpose, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

- III. When a patient wishes to apply for charity care sponsorship in the Program, the Patient shall complete a Confidential Financial Information form ("CFI") and provide necessary and reasonable supplementary financial documentation to support the entries on the CFI. The application procedures shall not place an unreasonable burden upon the patient, taking into account any barriers which may hinder the patient's capability of complying with the application procedures.
 - A. Any of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care sponsorship status: a "W-2" withholding statement; pay stubs; an income tax return from the most recently filed calendar year; forms approving or denying unemployment compensation; or written statements from employers or welfare agencies. In the event the Patient is not able to provide any of the documentation described above, the Hospital shall rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as an indigent person.
 - B. The Patient may also be asked to provide documentation of outstanding obligations and/or other financial resources (e.g., bank statements,).
- IV. Initial review of a patient's application and recommendation for approval of charity care sponsorship shall be the responsibility of appropriate hospital personnel, such as Patient Access, Social Work, or Patient Financial Services department. Patient Financial Services representative(s) shall make the "initial determination of sponsorship status," which means an indication, pending verification, that the services provided by the Hospital may or may not be covered by third party sponsorship, or an indication from the patient, pending verification, that he or she may meet the criteria for designation as an indigent person qualifying for charity care. Charity care determinations will preferably be made during pre-admission contacts but will be accepted during admission or at any other time. If the patient is unable to provide supporting documentation, the hospital may rely upon a written and signed statement from the patient. If it is obvious to hospital staff that a patient meets the criteria as an indigent person meeting the above income guidelines, it is not necessary to establish the exact income level or require supporting documentation. Examples of this might include an unemployed, homeless individual or someone whose eligibility has already been determined by a Community Health Clinic. An initial determination of sponsorship shall precede collection efforts directed at the patient, provided the patient is cooperative with the Hospital's efforts to reach an initial determination of sponsorship status. During the pendency, the Hospital may pursue reimbursement from any third-party coverage that may be available or identified to the Hospital.
- V. A patient who has been initially determined to meet the criteria for Program sponsorship shall be provided with at least fourteen (14) days, or such time as the patient's medical condition may require, or such time as may be reasonably necessary, to secure and present documentation supporting status as an indigent person, in accordance with WAC 246-453-030, prior to receiving a final determination of Program eligibility. If the patient does not respond to the Hospital's reasonable requests for information and/or documentary evidence within fourteen (14) days (or such time as may be necessary considering the patient's medical condition), the Hospital may deem the charity care application incomplete and pursue such collection activity as it deems necessary and appropriate.
- VI. In determining the status of a patient as an indigent person qualifying for charity care sponsorship in the Program, the Patient Financial Services Representative shall use the

criteria set forth in RCW 70.170.060 and WAC 246-453-010 et.seq., which includes a family income (as defined in WAC 246-453-010(17) which is equal to or below 200% of the published federal poverty standards, adjusted for family size, or is otherwise not sufficient to enable payment for the care or to pay deductibles or coinsurance amounts required by a third-party payer. In accordance with WAC 246-453-010(4), the patient must also have exhausted any third party payment sources, including (but not limited to) Medicare and DSHS Medicaid.

- A. Patients with family income equal to or below two hundred percent (200%) of the federal poverty standard, adjusted for family size, shall, pursuant to WAC 246-453-040(1) and SHB1616, be determined to be indigent persons qualifying for charity sponsorship for the full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship and provided that such patients are not eligible for other private or public health coverage sponsorship.
 - B. Patients with family income between two hundred-one and two hundred-fifty percent (201% - 250%) of the federal poverty standard, adjusted for family size, shall, pursuant to WAC 246-453-040(2) and SHB1616, be determined to be indigent persons qualifying for partial charity sponsorship of, which allows for discounts from charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship, in accordance with the Hospital's sliding fee schedule and policies regarding individual financial circumstances as set forth herein.
 - C. Patients with family income between two hundred-fifty one and three hundred percent (251% - 300%) of the federal poverty standard, adjusted for family size, shall, pursuant to WAC 246-453-040(2) and SHB1616, be determined to be indigent persons qualifying for partial charity sponsorship of, which allows for discounts from charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship, in accordance with the Hospital's sliding fee schedule and policies regarding individual financial circumstances as set forth herein.
 - D. Pursuant to WAC 246-453-040(3), the Hospital may, in appropriate circumstances and in its sole discretion, classify a patient whose family income exceeds three hundred percent of the federal poverty standard, adjusted for family size, as an indigent person eligible for a discount from charges based upon the patient's individual financial circumstances.
- VII. When the patient is eligible for and meets the guidelines and requirements for charity care sponsorship in the Program, the Patient Financial Services Representative shall forward such recommendation to the Patient Financial Services authorized designee for review. Within fourteen (14) days of receipt of all necessary information to make a final determination of Program eligibility, the Patient Financial Services designee shall notify the patient of the final determination, including a determination of the amount for which the patient will be held financially accountable.
- VIII. In the event of a recommendation of denial of an application for charity care sponsorship in the Program, the Patient Financial Services Representative shall forward such recommendation to the Patient Financial Services authorized designee for review. The Patient Financial Services designee will, after review of all relevant information, make a final determination of sponsorship status of the patient. The final determination shall be made within fourteen (14) days of receipt of all necessary information.

- IX. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income or family size to the Patient Financial Services department within thirty (30) days of receipt of notification. All appeals will be reviewed by the Patient Financial Services Director and the Chief Financial Officer or equivalent designee. If this determination affirms the previous denial of charity care, written notification will be sent to the patient/guarantor and the Department of Health in accordance with state law. The failure of a patient to reasonably complete appropriate application procedures shall be sufficient grounds for the Hospital to initiate collection efforts directed at the patient. Approval for charity care sponsorship will apply to the injury/illness currently being treated and extend to any other Hospital services that have been provided within a thirty (30) day period of time during which the patient qualifies for charity sponsorship in accordance with the Program. Hospital-based medical care services subsequently found to have met the charity care criteria at the time that services were rendered will be considered for Charity Care.

HOW TO APPLY

Any patient may apply to receive financial assistance/charity care by submitting an application and providing supporting documentation. If you have questions, need help, or would like to receive an application form or more information, please contact us:

- When you are checking in or checking out of the hospital;
- By telephone: 360-537-6101 Option 2 or 844-361-6044
- On our website at: **www.ghcares.org**
- In person: HRH Registration and/or Harbor Regional Health Medical Group
- To obtain documents via mail free of charge: 915 Anderson Drive, Aberdeen, WA 98520

If English is Not Your First Language: Translated versions of the application form, financial assistance policy, and this summary, are available upon request.

Other Assistance:

Coverage assistance: You may be eligible for other government and community programs. We can help you research whether these programs (including Medicaid/Apple Health and Veterans Affairs benefits) can help cover your medical bills. We will assist you in applying for these programs.

Uninsured/Prompt Pay discounts: We offer a discount for patients who do not have health insurance coverage, as well as discounts for prompt payment of outstanding balances. Please contact us about our discount programs.

Payment plans: Any balance for amounts owed by you is due within 30 days. The balance can be paid in any of the following ways: credit card, payment plan, cash, check, or online bill pay. If you would like to set-up a payment plan, please call the number on your billing statement.

MEDICAL STAFF AND ALLIED HEALTH PROFESSIONALS

Except as provided within this policy, Medical Staff members (and Allied Health Professionals) not employed by the Hospital are encouraged but not obligated to provide charity care in accordance with this Policy, and they may grant full or partial fee waivers in their discretion.

ATTACHMENTS

Attachment A: Financial Assistance Application and Confidential Financial Information Form

Attachment B: Schedule A: Harbor Regional Health Sliding Fee Schedule

Reviewing Body(ies): Board Finance Committee
Board of Commissioners

Authored By:

Patient Accounts Director

Date

Authenticated By:

Chief Financial Officer

Date



QUALITY, RISK, AND COMPLIANCE POLICY & PROCEDURE

Title: Patient Rights and Responsibilities

Number: QRC-103

Effective Date: 08/01/92

Revise Date: 01/26/15; 01/03/22

Review Date: 12/26/18

I. PURPOSE:

To provide patients, family members, visitors, medical, and hospital staff with a statement of patient rights and patient responsibilities. The expectation is that observance of these rights and responsibilities will contribute to more effective patient care and greater satisfaction for the patient, provider, and hospital staff.

II. POLICY:

It is the policy of Harbor Regional Health that the rights and responsibilities of the patient shall be defined and communicated to patients, family, and medical and hospital staff. This policy identifies the patient rights and responsibilities and the HRH process of informing the patient or representative of those rights and responsibilities.

III. PROCEDURE:

Patient Handbook:

All patients who are registered for services are given a Patient Handbook, which contains the patient's bill of rights and responsibilities as identified in this policy. All Admissions, Day Surgery, Emergency Room & Family Birth Center patients receive a Patient Handbook at every encounter. This is documented in the Meditech Admission Module and prints on the patient face sheet. Outpatients receive the Patient Handbook yearly and this is documented in the Admission Module and prints on the patient face sheet.

Public Postings:

A copy of the patient's bill of rights and responsibilities will be publically posted in all HRH facilities in accordance with section 1557 of the Affordable Care Act. This posting will include taglines in the top 15 languages spoken by individuals with LEP in Washington State, and advise patients of the availability of free language assistance services.

IV. PATIENT RIGHTS:

We believe patient rights are paramount to our mission, vision and values; therefore, we state them here for you and your family or loved ones to review. We will do everything possible to make sure that your rights are respected. Likewise, Harbor Regional Health has a right to expect reasonable and responsible behavior from patients, their relatives and friends. The following patient rights and responsibilities are applicable to all Harbor Regional Health patients:

Access to Care

Individuals shall be given unbiased access to treatment or accommodations that are available or medically indicated regardless of race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, source of payment, sex, sexual orientation, and gender identity or expression.

All individuals presenting to the hospital emergency department, regardless of ability to pay, have a right to access emergency medical treatment to stabilize an identified emergency medical condition.

Patients have the right to have access to spiritual care.

Respect and Dignity

You have the right to receive considerate, respectful care at all times and under all circumstances, with recognition of personal dignity, diversity, and religious or other spiritual preferences.

Communication

You have the right to receive information you can understand. This includes access to an interpreter or translation services at no charge.

You have the right to a prompt and reasonable response to questions and request, regarding your care. Additionally, you have the right to know the reasons for any proposed change in the attending physicians and professional staff responsible for your care. You also have the right to know the reasons for your transfer either within or outside of the hospital.

Patients have the right to know the name of the doctor and other practitioners who have primary responsibility for their care, and to know the identity and professional status of individuals responsible for authorizing and performing procedures and care.

Patients have the right to receive beneficiary notices including:

- Notice of non-coverage and right to appeal premature discharge (IM / IMM); and
- Medicare Outpatient Observation Notice (MOON)

Informed Patient Care

You have the right to obtain, from the practitioners responsible for coordinating and providing your care, complete and current information about diagnosis (to the degree known), treatment, alternatives, referral information, risks and any known prognosis. This information should be communicated in terms you can understand.

HRH encourages patients and family members or representatives to be involved in and have an understanding of your medical condition and treatment plan. You have the right to have your family or representative involved in care, treatment and service decisions, as allowed by law. You also have the right to be involved in the resolution of problems associated with care decisions.

To supportive care, including appropriate assessment and management of pain, treatment of uncomfortable symptoms and support of your emotional and spiritual needs, regardless of your medical status or treatment decisions. You have the right to be informed about unanticipated or adverse outcomes associated with your care.

You have the right to refuse treatment. You or your legal representative may refuse treatment to the extent permitted by law. When refusal of treatment by you or your legal representative prevents the provision of appropriate care in accordance with professional standards, our relationship with you may be terminated upon reasonable notice.

Healthcare Decisions and End of Life

Advance Directives:

You have the right to receive information about advance directives. Advance directives ensure that your wishes, in written form, are carried out. When your advance directives are presented in a valid format, HRH will honor your wishes and retain them in your medical record when appropriate. The most common type of advance directives include:

- Physician Order for Life-Sustaining Treatment (POLST)
- Durable Power of Attorney for Healthcare
- Healthcare Directive or Living Will
- Mental Health Advance Directive

For more information, contact your attorney or request more information from a member of your care team.

Healthcare Proxy (Surrogate Decision-Makers):

If you are unable to make decisions or communicate with us about your healthcare, Washington State law allows the following people, in order of priority, to make healthcare decisions for you:

- A legal guardian with healthcare decision-making authority, if one has been appointed
- The person named in the Durable Power of Attorney for Healthcare
- Your spouse or state-registered domestic partner
- Your children who are 18 years or older
- Your mother or father
- Your adult brothers and sisters

CPR and DNAR:

It is important for patients to understand their rights when it comes to cardiopulmonary resuscitation (CPR) and do not attempt resuscitation (DNAR). While the sudden stopping of the heart (cardiac arrest) may result in unexpected death, it can also be the natural end to chronic pain and suffering experienced by some patients.

Cardiopulmonary resuscitation is a medical procedure involving repeated compression of a patient's chest, performed in an attempt to restore the blood circulation and breathing of a person who has suffered cardiac arrest. It is Harbor Regional Health's policy to perform CPR on all patients whose heart stops suddenly unless a doctor writes a DNAR order or a physician order for life-sustaining treatment (POLST).

We encourage you and your family to talk with your provider or a member of the social work team about your wishes regarding end of life care. It is very important to know your wishes when you are admitted. You may request to have a DNAR or POLST order or your doctor may write an order when, in their medical judgment, initiating CPR would clearly be futile.

Organ Donation:

Patients have the right to determine whether they would like to donate organs, skin and other tissues. Every year donations help thousands of individuals in need. If you want to be an organ donor, please tell your doctor and your family. During organ donation, the body is treated with respect and dignity, and funerals do not need to be delayed. All costs related to organ or tissue donation are covered by the procurement organization. Please let your healthcare team know if this is something you would like to consider.

Safety and Security

Patient Safety is paramount at Harbor Regional Health. It is our goal to ensure you receive care in a safe and secure healing environment. We empower our patients to take an active role in ensuring they receive care that is safe and secure. Patients are encouraged to provide any recommendations or report any concerns to a member of your healthcare team or to the Patient Safety Hotline (360) 537-5437.

Patients have the right to be free from all forms of abuse or harassment. Furthermore you have the right to request information about and the ability to contact protective services.

Additionally, you have the right to be free from seclusion and the use of any restraint that is not medically necessary. These measures are determined by your physician and used only to prevent injury to yourself or others and when alternative, less restrictive measures have been considered.

Privacy and Confidentiality

You have the right, within the law, to personal and informational privacy, as demonstrated by the following rights:

- If an inpatient, to refuse to speak with or see anyone not officially connected with the hospital, including visitors or persons officially connected with the hospital but not directly involved in patient care.
- To be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy. This includes the right to request to have another person present during certain parts of a physical examination, treatment or procedure performed by a health professional of the opposite sex.
- To expect that any discussion or consultation involving your care will be conducted discreetly and that individuals not directly involved in your care will not be present without permission.
- To have medical record accessed only by individuals for legitimate business purposes and as permitted under law.
- To expect all communications and other records pertaining to care, including the source of payment, be treated as confidential.

Access to Medical Records

You have the right to access your medical records, including current medical records, upon an oral or written request, in the form and format requested by you, if it is readily producible in such form and format. This includes an electronic form or format when such medical records are maintained electronically; or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the patient, and within a reasonable time frame. Requests for records can be made to the Health Information Management (HIM) Release of Information (ROI) Department for your respective care location:

HRH Community Hospital

915 Anderson Drive
Aberdeen, WA 98520
P: (360) 537-5196
F: (360) 537-0588

HRH Medical Group

1006 North H Street
Aberdeen, WA 98520
P: (360) 537-6182
F: (360) 537-6198

Additional information on release of information can be found at:

<https://www.ghcares.org/patient-forms>

Rules and Regulations

You have the right to know what rules and regulations apply to patients. These rules include those described in this Patient Handbook, outlined in the responsibilities section of this booklet and those posted on campus. Additional copies of the Patient Handbook and Patient Rights and Responsibilities are available at the registration desk or by contacting the Patient Advocate at (360) 537-5134.

Patient Experience

Harbor Regional Health employs a patient advocate to assist you and your family by answering questions, addressing concerns and connecting you to resources and information at the hospital. If you would like to share a compliment for the individual or department who gave you or your family care, please contact our Patient Advocate at (360) 537-5134.

Patients also have the right to file a complaint or grievance without the fear of retribution or denial of care, and to receive timely complaint resolution. Harbor Regional Health has a complaint procedure that ensures the continuity of your care. If a current patient of HRH or their legal representative has concerns or complaints about any part of their care you are encouraged to speak with any department director or staff member on the unit or in the clinic. Post-discharge or post-visit concerns or complaints may be brought to the attention of the patient advocate by contacting them at (360) 537-5134. Please know that our team members will not respond to complaints via unsecure methods such as e-mail or text message.

If you feel that you have been unable to resolve your concern through the Patient Advocate you have the right to contact:

Harbor Regional Health
Director of Quality, Risk and Compliance
915 Anderson Drive
Aberdeen, WA 98520
P: (360) 537-5126

DNV Healthcare
Attn: Complaint Department
400 Techne Center Drive
Milford, OH 45150
P: (866) 496-9647
www.dnvglhealthcare.com/patient-complaint-report

Washington State Department of Health
HSQA Complaint Intake
Post Office Box 47857
Olympia, WA 98504-7857
P: (360) 236-4700
E-mail: HSQAComplaintintake@doh.wa.gov

If the patient is a Medicare beneficiary and has a complaint regarding quality of care, their Medicare coverage, or premature discharge, the patient may contact:

Kepro-Region 10
5201 West Kennedy Blvd
Suite 900
Tampa, FL 33609
P: (888) 305-6759
F: (844) 878-7921

V. PATIENT RESPONSIBILITIES

Respect and Consideration

Harbor Regional Health believes in maintaining a therapeutic and healing environment for all patients. You are responsible for being considerate of the rights of other patients and HRH staff. This includes, but is not limited to, excessive or repetitive noise, threatening or abusive language or a display of hostility directed at staff or other patients, throwing objects, tampering with property, theft, or damage to facilities or equipment, degrading or demeaning comments, sexual comments or offensive gestures, profanity or similar language while speaking with staff or other patients, inappropriate or intimidating physical contact or threat of physical contact with another individual, or possession and use of alcohol or illegal substances while on premises. You understand that any abusive, disruptive, or disrespectful behavior could result in your dismissal from Harbor Regional Health.

Safety

We feel that you as a patient are an integral member of our team, when it comes to safety. This is facilitated by you becoming an active, involved and informed member of the health-care team itself. Therefore, you have the responsibility to:

- Work with your physician, nurse and other health-care members to make decisions about your care;
- Notify your non-Harbor Regional Health primary care physician of changes to your plan of care;
- Ask family members or friends to be a part of the health-care team if you are very sick;
- Ask questions until you understand the answers (about diagnoses, treatments, procedures, medications, etc.)
- Learn about the possible risk of refusing a test or procedure;
- Ask why a test or treatment is needed, how it can help you and if you would be better off without it. Know that more is not always better.
- Make sure that you, your physician, and your surgeon all agree and are clear on exactly what will be done if you are having surgery;
- Ask your doctor or health-care providers to explain the recommended or prescribed treatment plan;
- Ask for information about your medicines, if any, in terms you can understand. You need to know:
 - What it is for
 - How to take it
 - How long to take it
 - What to do if there are side effects
 - If it is safe to take with other medicines, foods and supplements
 - What food, drink and activities to avoid
 - Where to store it

Pain Management

You are responsible for:

- Working with the physician or nurse to develop a pain-management plan
- Asking the physician or nurse what to expect of pain and pain management
- Helping the physician and nurse assess your pain
- Discussing pain relief options with physicians and nurses

- Telling the physician or nurse about any concerns you have about taking pain medication
- Asking for pain relief when pain first begins
- Complying with physician orders regarding medication
- Telling the physician or nurse if and when pain is not relieved
- Not taking any medication or substance that has not been prescribed by your physician

Communicating Information

As a patient, you are an integral part of the health-care team. Therefore, you are responsible for:

- Participating in your care and health-care decisions
- Providing, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, allergies and other matters relating to your health
- Reporting unexpected changes in your condition to the responsible practitioner
- Communicating whether you clearly understand your plan of care and what is expected of you

Education

You are expected to participate in the teaching/learning process so that you will acquire and understand the skills and behaviors that promote recovery, maintain or improve function, or manage disease or symptom progression.

Advance Directives

You are responsible for providing a copy of your advance directive (e.g. power of attorney for healthcare, POLST, etc.) to an HRH representative in registration or a member of your HRH Health Care Team for retention in your medical record. Furthermore, you are responsible for informing HRH and your healthcare providers if you create, modify or revoke any advance directive. An advance directive is not required to receive treatment and you may waive your right to make one.

Charges

You are responsible for providing updated financial information and meeting any financial obligation to the hospital as timely as possible.

Compliance

You are responsible for following the treatment plan recommended by the practitioner primarily responsible for your care. This may include following the instructions of nurses and allied health staff as they carry out your plan of care, implement the responsible practitioner's orders and enforce applicable clinic rules and regulations. Furthermore, you are responsible for keeping appointments and for notifying HRH when you are unable to do so.

Refusing Treatment

You are responsible for your actions and potential adverse outcomes, should you refuse treatment or do not follow the practitioner's instructions.

Personal Property

You may have personal items with you during your visit or stay; however, Harbor Regional Health is not responsible for personal items you bring to the hospital or clinics. This includes cash, valuables, electronics, jewelry, eyeglasses, hearing aids, dentures, canes, prostheses, wheelchairs and other easily misplaced items.

If you are an inpatient, please leave all jewelry and valuables at home or send them home with a family member or a person whom you trust to properly secure them. If necessary and upon requests, hospital staff may store smaller valuables in the hospital safe.

Under no circumstance will the HRH or HRH Staff maintain or control possession of alcohol, drugs or drug paraphernalia. These items will be appropriately discarded or destroyed if brought to the facility.

Ethics Consultation

Ethics consultations are available for patients and family members who are faced with an ethical dilemma regarding patient care. The Ethics Committee is available to consult on such issues as extent of treatment and decision making. A consultation can be initiated by contacting your doctor, nurse manager or other member of your healthcare team.

References:

[WAC 246-320-141 Patient Rights and Organizational Ethics](#)

[42 CFR §482.13 Patient Rights](#)

DNV NIAHO Standards Manual: Patient Rights (PR)

Reviewing Entity: Board Quality, Safety and Compliance

Director of Quality, Risk, and Compliance

Date

Authenticated By:

Chief Executive Officer

Date



HOSPITAL POLICY AND PROCEDURE

Title: Patient Non-Discrimination Policy

Number: A723

Effective Date: 03-19-14

Revise Date:

Review Date (no revisions): 01/31/18

PURPOSE

To ensure that all patients and visitors of Grays Harbor Community Hospital are treated with equality, in a welcoming, nondiscriminatory manner, consistent with applicable state and federal law.

SCOPE: This policy applies to all members of the Grays Harbor Community Hospital workforce, including employees, medical staff members, contracted service providers, and volunteers, and to all vendors, representatives, and any other individuals providing services to or on behalf of Grays Harbor Community Hospital ("Hospital Personnel").

POLICY

Grays Harbor Community Hospital is dedicated to providing services to patients and welcoming visitors in a manner that respects, protects, and promotes patient rights.

1. Hospital Personnel will treat all patients and visitors receiving services from or participating in other programs of Grays Harbor Community Hospital and its affiliated clinics with equality in a welcoming manner that is free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law.
2. Hospital Personnel will inform patients of the availability of and make reasonable accommodations for patients consistent with federal and state requirements. For example, language interpretation services will be made available for non-English speaking patients and sign language interpretation will be made available for hearing impaired patients.
3. Hospital Personnel will afford visitation rights to patients free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law and will ensure that visitors receive equal visitation privileges consistent with patient preferences.
4. Any person who believes that he, she, or another person has been subjected to discrimination which is not permitted by this Policy, may file a complaint using Grays Harbor Community Hospital's complaint and grievance procedure.
5. Hospital Personnel are prohibited from retaliating against any person who opposes, complains about, or reports discrimination, files a complaint, or cooperates in an investigation of discrimination or other proceeding under federal, state, or local anti-discrimination law.

Procedure:

1. Grays Harbor Community Hospital's Corporate Compliance Officer/Patient Advocate or designee is responsible for coordinating compliance with this Policy, including giving notice to and training all Hospital Personnel on this Policy.
2. Hospital Personnel will determine eligibility for and provide services, financial aid, and other benefits to all patients in a similar manner, without subjecting any individual to separate or different treatment on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law.
3. Hospital Personnel will provide notices to patients regarding this Nondiscrimination Policy and Grays Harbor Community Hospital's commitment to providing access to and the provision of services in a welcoming, nondiscriminatory manner.
4. At the time patients are notified of their patient rights through the Patient Handbook, Hospital Personnel will also inform each patient, or the patient's support person, including the patient's attorney in fact, when appropriate, of the patient's visitation rights, including any clinical restriction on those rights, and the patient's right, subject to the patient's consent, to receive visitors whom the patient designates, free of discrimination based upon age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law. Such visitors include a spouse, state registered domestic partner (including same-sex state registered domestic partner), another family member, friend, or a legal representative of the patient, such as an attorney-in-fact. Hospital Personnel will also notify patients of their right to withdraw or deny such consent at any time. Hospital Personnel will afford such visitors equal visitation privileges consistent with the patient's preferences.
5. Any Hospital Personnel receiving a patient or visitor discrimination complaint will advise the complaining individual that he or she may report the problem to the Hospital Administration and file a complaint without fear of retaliation.

Related Policies:

A702 Patients Beneficiaries Nondiscrimination

A703 Grievance Procedure – Section 504 - Disability

QUR 102 Patient Grievance

Reviewed by: Director of Quality/Safety/Compliance

Author of Policy:

Chief Nursing Officer

Date

Authenticated By:

President/CEO

Date

HOSPITAL POLICY AND PROCEDURE

Title: The Washington State Death with Dignity Act

Number: A722

Effective Date: 08/23/10

Revised Date: 01-30/18 (minor revisions)

Review Date: 02/24/16

PURPOSE

The Board of Directors of Grays Harbor Community Hospital, acting on the recommendation of the Medical Staff, resolved to allow participation in the Washington State Death with Dignity Act (referred to as “the Act”) (RCW 70.725) on February 25, 2009. This policy describes and mandates the implementation of the Act at Grays Harbor Community Hospital. Our goal is to assist patients to make informed end-of-life care decisions.

POLICY

Grounded in the hospital’s core values of Respect and Compassion, the hospital recognizes the array of emotional, spiritual, psychological and social reactions that patients and families face when confronted with end-of-life decisions and care planning.

Grays Harbor Community Hospital allows providers to participate in the “Washington State Death with Dignity Act” if they so choose. This means that providers at Grays Harbor Community Hospital may:

- Perform the duties of an attending physician;
- Perform the duties of a consulting physician;
- Prescribe life-ending medication;
- Fill a prescription for life-ending medication;
- Provide counseling in connection with the provision of life-ending medication; and/or
- Perform other duties as provided for and described in the Act

PROCEDURE

When a Grays Harbor Community Hospital provider participates in any action defined by the Act with a “qualified patient” within this hospital, that provider must, within an hour of the action, notify the CMO or the on-call administrator of the fact.

It is the provider’s responsibility to ensure that the correct procedures are followed and that the correct documentation is completed in accordance with the Act and this policy. The steps included in (attachment 1) “The Washington Death with Dignity Checklist” prepared by the Washington State Hospital Association shall be carefully followed and documented.

Executive administrators of the hospital may review medical records of qualified patients, to the extent necessary, to ensure all the safeguards of the Act have been followed and that the required documentation has been completed and submitted to the Washington State Department of Health.

Grays Harbor Community Hospital does not mandate that any provider participate in the Act, nor encourage any provider to do so.

Providers and hospital staff are expected to respond to any patient’s questions about life-ending medication with openness and compassion. The Washington State Hospital Association informational brochure is available as a resource to provide to patients and family members (attachment 2). The Palliative Care Consult Team is also available as a referral resource for

providers. Social Services are available for staff member referrals. Both resources can provide supportive care that exceeds the Hospital's obligation to openly discuss the patient's concerns, unmet needs, feelings and desires about dying and to explore the meaning behind the patient's questions and help discover options which may not have been considered.

The attending physician shall encourage any qualified patient to complete a POLST form and ensure that it is placed in the medical record. The attending physician shall encourage and refer a qualified patient to a Hospice program in order to increase the chance that things will go smoothly at the time of death.

GHCH Pharmacy formulary does not include the medications customarily prescribed for this purpose and therefore, providers will need to seek an outside source to assist a qualified patient in obtaining the recommended medications.

Reviewing Bodies:

Ethics Committee Task Team on I-1000
Palliative Care Consult Team
MEC

Reference Materials:

RCW 70.725, Washington State Death with Dignity Act
Washington State Department of Health rules 246-978WAC
Washington State Hospital Association I-1000 Resources
Oregon State Death with Dignity Act Guidelines
Board of Directors Resolution, February 25, 2009
Medical Executive Committee minutes of April 14, 2009

Attachments:

Washington State Hospital Association I-1000 Resources
Washington State Hospital Association Informational Brochure
Attending Physician's Compliance Form
Consulting Physician's Compliance Form
Psychiatric Consultant's Compliance Form
Attending Physician's after Death Report Form
Patient's Written Request Form

Authored By:

Ethics Committee Chair

Date

Approved By:

CNO

Date

CEO

Date

HOSPITAL POLICY AND PROCEDURE

Title: Reproductive Health Care for Women

Number: A725

Effective Date: 03-19-14

Revise Date: 10-24-19

Review Date (no revisions): 11-10-17

PURPOSE

Within the framework of the World Health Organization's definition of reproductive health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, Grays Harbor Community Hospital supports the sexual rights of all persons which must be respected, protected and fulfilled.

POLICY

This policy defines the woman's right to appropriate health care services that will enable her to go safely through pregnancy and childbirth and the freedom to decide if, when and how often to reproduce.

Depending on services needed, care is provided in the Family Birth Center, Emergency Department, and Surgical Department. Grays Harbor Community Hospital does not provide medical or elective termination of pregnancies. Tubal ligation and vasectomy procedures are available. Specialized services are provided to victims of sexual assault.

The hospital and community physicians provide information and resources for patients, who are seeking termination of a pregnancy, infertility care, and safe, effective, acceptable methods of birth control.

References

WHO: Reproductive Health

Reproductive Health Strategy – World Health Organization

CDC Division of Reproductive Health

Authored By:

Chief Nursing Officer

Date

Authenticated By:

President/CEO

Date

Exhibit 6
Harbor Regional Financials

**Grays Harbor Community Hospital
Cardiac Program
2022 and Pro Forma**

**Comparison Statement of Revenue and
Expense-Unrestricted Funds_PCI PROJECT
SPECIFIC ONLY**

	2022 Actual	2023 Budget	2024 Projection	2025 Projection	2026 Projection
Revenues					
Inpatient Revenue	\$ 5,230,678	\$ 4,213,477	\$ 4,424,151	\$ 4,645,358	\$ 4,877,626
Outpatient Revenue	2,307,075	3,557,956	7,820,265	8,054,873	8,296,519
ER Revenue	10,217	-	-	-	-
Physician Revenue	429,005	429,005	450,455	472,978	496,627
Gross Patient Revenue	7,976,975	8,200,438	12,694,871	13,173,209	13,670,772
Revenue Deductions					
Bad Debt	-	-	168,076	174,409	180,996
Charity	-	-	40,418	41,941	43,525
Other Deductions	5,479,217	4,432,709	7,219,841	7,448,402	7,740,167
Total Revenue Deductions	5,479,217	4,432,709	7,428,335	7,664,751	7,964,689
Net Patient Revenue	2,497,758	3,767,729	5,266,536	5,508,458	5,706,084
Other Revenue	-	-	-	-	-
Net Operating Revenue	2,497,758	3,767,729	5,266,536	5,508,458	5,706,084
Expenses					
Salaries	59,404	41,844	45,192	45,192	45,192
Benefits	10,356	14,542	15,269	16,033	16,834
Professional Fees	1,756,688	2,527,780	2,603,613	2,655,686	2,708,799
Supplies	229,936	239,092	358,638	358,638	358,638
Utilities	3,601	4,212	4,212	4,212	4,212
Purchased Services	566,118	774,768	774,768	774,768	774,768
Agency	1,183,035	1,183,000	1,183,000	1,183,000	1,183,000
Rent/Lease	-	-	-	-	-
Insurance	-	-	-	-	-
Other	11,018	-	-	-	-
Subtotal Expenses	3,820,156	4,785,238	4,984,692	5,037,528	5,091,443
Earnings Before Interest Depreciation & Amortization (EBIDA)	(1,322,398)	(1,017,509)	281,844	470,930	614,641
Depreciation & Amortization	55,935	65,136	65,136	65,136	65,136
Interest	-	-	-	-	-
Total Depreciation, Amortization and Interest	55,935	65,136	65,136	65,136	65,136
Net Operating Income (Loss)	(1,266,463)	(952,373)	346,980	536,066	679,777
Non-Operating Income (Loss)	-	-	-	-	-
Net Income	\$ (1,266,463)	\$ (952,373)	\$ 346,980	\$ 536,066	\$ 679,777

**Grays Harbor Community Hospital
Consolidated Income Statement
2022 and Pro Forma**

**Comparison Statement of Revenue and Expense-
Unrestricted Funds_HOSPITAL AGGREGATE WITH
PCI PROJECT**

	2022 Actual	2023 Budget	2024 Projection	2025 Projection	2026 Projection
Revenues					
Inpatient Revenue	\$ 137,923,293	\$ 142,760,723	\$ 147,043,545	\$ 151,454,851	\$ 155,998,497
Outpatient Revenue	153,730,376	159,670,774	168,723,206	178,047,211	187,650,937
ER Revenue	91,454,957	95,130,377	97,984,288	100,923,817	103,951,531
Physician Revenue	7,443,234	7,349,578	7,570,065	7,797,167	8,031,082
Gross Patient Revenue	390,551,860	404,911,452	421,321,105	438,223,047	455,632,047
Revenue Deductions					
Bad Debt	5,170,775	4,075,752	4,198,025	4,323,965	4,453,684
Charity	1,243,441	1,286,948	1,331,991	1,378,611	1,426,862
Contractual Adj and Other Deductions	288,533,633	300,167,120	312,173,805	324,660,757	337,647,187
Total Revenue Deductions	294,947,849	305,529,820	317,703,821	330,363,333	343,527,734
Net Patient Revenue	95,604,011	99,381,632	103,617,284	107,859,714	112,104,313
Other Revenue	6,184,119	6,045,758	6,166,673	6,290,007	6,415,807
Net Operating Revenue	101,788,130	105,427,390	109,783,957	114,149,720	118,520,120
Expenses					
Salaries	39,243,067	44,874,698	46,220,939	47,607,567	49,035,794
Benefits	11,259,503	12,467,207	12,841,223	13,226,460	13,623,254
Professional Fees	12,010,923	12,529,929	12,905,827	13,293,002	13,691,792
Supplies	11,220,988	10,810,286	11,134,595	11,468,632	11,812,691
Utilities	1,195,524	1,354,386	1,395,018	1,436,868	1,479,974
Purchased Services	12,896,647	13,500,097	13,905,100	14,322,253	14,751,920
Agency	11,652,625	2,257,345	2,325,065	2,394,817	2,466,662
Rent/Lease	740,837	716,277	737,765	759,898	782,695
Insurance	1,144,784	1,121,986	1,155,646	1,190,315	1,226,024
Other	1,971,803	2,136,572	2,200,669	2,266,689	2,334,690
Subtotal Expenses	103,336,701	101,768,783	104,821,846	107,966,502	111,205,497
Earnings Before Interest Depreciation &	(1,548,571)	3,658,607	4,962,111	6,183,218	7,314,623
Depreciation & Amortization	2,891,748	3,011,175	3,101,510	3,194,556	3,290,392
Interest	1,922,624	1,932,559	1,990,536	2,050,252	2,111,759
Total Depreciation, Amortization and Interest	4,814,372	4,943,734	5,092,046	5,244,807	5,402,152
Net Operating Income (Loss)	(6,362,943)	(1,285,127)	(129,935)	938,411	1,912,472
Non-Operating Income (Loss)	(800,247)	933,726	500,000	500,000	500,000
Net Income	\$ (7,163,190)	\$ (351,401)	\$ 370,065	\$ 1,438,411	\$ 2,412,472

**Grays Harbor Community Hospital
Consolidated Income Statement
2022 and Pro Forma**

Comparison Statement of Revenue and Expense-
Unrestricted Funds_HOSPITAL AGGREGATE
WITHOUT PROJECTPCI PROJECT SPECIFIC ONLY

	2022 Actual	2023 Budget	2024 Projection	2025 Projection	2026 Projection
Revenues					
Inpatient Revenue	\$ 137,923,293	\$ 142,760,723	\$ 142,619,394	\$ 146,809,493	\$ 151,120,870
Outpatient Revenue	153,730,376	159,670,774	160,902,941	169,992,338	179,354,418
ER Revenue	91,454,957	95,130,377	97,984,288	100,923,817	103,951,531
Physician Revenue	7,443,234	7,349,578	7,119,610	7,324,189	7,534,455
Gross Patient Revenue	390,551,860	404,911,452	408,626,233	425,049,837	441,961,275
Revenue Deductions					
Bad Debt	5,170,775	4,075,752	4,029,949	4,149,556	4,272,688
Charity	1,243,441	1,286,948	1,291,573	1,336,670	1,383,337
Contractual Adj and Other Deductions	288,533,633	300,167,120	304,953,964	317,212,355	329,907,020
Total Revenue Deductions	294,947,849	305,529,820	310,275,486	322,698,582	335,563,045
Net Patient Revenue	95,604,011	99,381,632	98,350,748	102,351,255	106,398,230
Other Revenue	6,184,119	6,045,758	6,166,673	6,290,007	6,415,807
Net Operating Revenue	101,788,130	105,427,390	104,517,421	108,641,262	112,814,036
Expenses					
Salaries	39,243,067	44,874,698	46,175,747	47,562,376	48,990,603
Benefits	11,259,503	12,467,207	12,825,954	13,210,427	13,606,420
Professional Fees	12,010,923	12,529,929	10,302,213	10,637,316	10,982,992
Supplies	11,220,988	10,810,286	10,775,957	11,109,994	11,454,053
Utilities	1,195,524	1,354,386	1,390,806	1,432,656	1,475,762
Purchased Services	12,896,647	13,500,097	13,130,332	13,547,485	13,977,152
Agency	11,652,625	2,257,345	1,142,065	1,211,817	1,283,662
Rent/Lease	740,837	716,277	737,765	759,898	782,695
Insurance	1,144,784	1,121,986	1,155,646	1,190,315	1,226,024
Other	1,971,803	2,136,572	2,200,669	2,266,689	2,334,690
Subtotal Expenses	103,336,701	101,768,783	99,837,154	102,928,974	106,114,054
Earnings Before Interest Depreciation &	(1,548,571)	3,658,607	4,680,266	5,712,288	6,699,982
Depreciation & Amortization	2,891,748	3,011,175	3,101,510	3,194,556	3,290,392
Interest	1,922,624	1,932,559	1,990,536	2,050,252	2,111,759
Total Depreciation, Amortization and Interest	4,814,372	4,943,734	5,092,046	5,244,807	5,402,152
Net Operating Income (Loss)	(6,362,943)	(1,285,127)	(411,780)	467,481	1,297,831
Non-Operating Income (Loss)	(800,247)	933,726	500,000	500,000	500,000
Net Income	\$ (7,163,190)	\$ (351,401)	\$ 88,220	\$ 967,481	\$ 1,797,831

GHCH
Consolidating Balance Sheet

	As Of 12/31/22	Pro Forma 2023	Pro Forma 2024	Pro Forma 2025	Pro Forma 2026
Current Assets					
Cash	\$ 5,548,775	\$ 4,948,775	\$ 5,348,775	\$ 5,598,775	\$ 6,098,775
Patient Receivables:					
Gross Patient Receivables	68,819,286	65,735,877	60,577,935	60,577,935	60,577,935
Less Allowance for Uncollectibles	(45,678,442)	(43,631,845)	(40,208,288)	(40,208,288)	(40,208,288)
Net Patient Receivables	23,140,844	22,104,032	20,369,647	20,369,647	20,369,647
Other Receivables	2,638,087	1,981,717	1,182,006	1,182,006	1,182,006
Inventories	2,133,047	2,111,879	2,124,831	2,124,831	2,124,831
Prepaid Expense	715,339	880,294	576,944	576,944	576,944
Other Current Assets	62,010	1,583,270	224,043	224,043	224,043
Total Current Assets	34,238,102	33,609,967	29,826,246	30,076,246	30,576,246
Investment Balances (Unrestricted)	5,993,771	6,113,646	6,235,919	6,360,638	6,487,850
Assets Limited as to Use					
<u>Cash and Cash Equivalents</u>					
Board Designated	-	-	-	-	-
Temporarily Restricted	1,838,994	2,045,435	2,106,798	2,170,002	2,235,102
Bond Reserve	2,396,450	2,396,450	2,396,450	2,396,450	2,396,450
	4,235,444	4,441,885	4,503,248	4,566,452	4,631,552
<u>Investments</u>					
Endowment Corpus	5,331,811	5,324,782	5,324,782	5,324,782	5,324,782
Total Assets Limited as to Use	9,567,255	9,766,667	9,828,030	9,891,234	9,956,334
Property, Plant & Equipment					
Land & Land Improvements	2,364,526	2,364,526	2,364,526	2,364,526	2,364,526
Building & Improvements	68,833,125	68,833,125	68,833,125	68,833,125	68,833,125
Medical Office Building	1,434,119	1,434,119	1,317,699	1,317,699	1,317,699
Equipment	44,827,540	44,654,158	43,778,272	43,778,272	43,778,272
CIP	746,443	628,808	236,401	236,401	236,401
Total Fixed Assets	118,205,753	117,914,736	116,530,023	116,530,023	116,530,023
Accumulated Depreciation	(88,406,066)	(88,159,462)	(85,476,390)	(85,476,390)	(85,476,390)
Net Property, Plant & Equipment	29,799,687	29,755,274	31,053,633	31,053,633	31,053,633
Other Assets					
Other Non Current Assets	2,005	2,005	2,005	2,005	2,005
Intangible--Pension	5,037,530	4,797,559	2,157,878	2,157,878	2,157,878
Deferred Pension Outflows	702,962	828,343	2,207,534	2,207,534	2,207,534
Total Other Assets	5,742,497	5,627,907	4,367,417	4,367,417	4,367,417
TOTAL ASSETS	<u>\$ 85,341,312</u>	<u>\$ 84,873,461</u>	<u>\$ 81,311,245</u>	<u>\$ 81,749,167</u>	<u>\$ 82,441,480</u>
	As Of 12/31/22	Pro Forma 2023	Pro Forma 2024	Pro Forma 2025	Pro Forma 2026
Current Liabilities					
Short Term Notes Payable	\$ -	\$ -	\$ -	\$ -	\$ -
Accounts Payable	16,281,692	14,504,628	13,379,558	12,958,057	11,814,966
Due to Third Parties	2,046,059	2,021,059	2,021,059	2,021,059	2,021,059
Payroll & Related	3,745,421	4,706,482	4,800,612	4,896,624	4,994,556
Other Current Liabilities	2,948,565	4,406,641	2,800,735	2,800,735	2,800,735
Current Portion -LT Debt	-	-	-	-	-
Total Current Liabilities	25,021,737	25,638,810	23,001,964	22,676,475	21,631,316
Long Term Liabilities					
Deferred Pension Liabilities	4,744,698	4,688,704	4,072,770	4,072,770	4,072,770
Due to/from Affiliates	-	-	-	-	-
Bonds Payable (Net of Prem/Disc)	34,380,644	33,705,644	33,030,644	32,355,644	31,680,644
Total Liabilities	64,147,079	64,033,158	60,105,378	59,104,889	57,384,730
EQUITY					
Equity	21,527,709	14,364,519	14,013,118	14,383,183	15,821,594
Board Designated Net Assets	-	-	-	-	-
Temporarily Restricted Net Assets	-	4,500	-	-	-
Permanently Restricted Net Assets	5,331,811	5,324,782	5,324,782	5,324,782	5,324,782
Reserve for Pension/Other	1,497,903	1,497,903	1,497,903	1,497,903	1,497,903
Net Income(Loss)--Current Year	(7,163,190)	(351,401)	370,065	1,438,411	2,412,472
Total Equity	21,194,233	20,840,303	21,205,868	22,644,279	25,056,750
TOTAL LIABILITIES & EQUITY	<u>\$ 85,341,312</u>	<u>\$ 84,873,461</u>	<u>\$ 81,311,245</u>	<u>\$ 81,749,167</u>	<u>\$ 82,441,480</u>